Addictions

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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (925-8951)

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Addictions

SUMMER, 1961

EDITOR'S NOTE: Henceforth this quarterly publication will be known simply as ADDICTIONS — a name that indicates a broader scope, as indeed, does the new name of the former Alcoholism Research Foundation.

The Alcoholism and Drug Addiction Research Foundation is privileged to lead off this first issue of ADDICTIONS with some highly relevant thoughts set down by Dr. Erik Jacobsen. Dr. Jacobsen is the distinguished Danish pharmacologist of the Medicinalco Research Laboratory, Copenhagen, who gave the world antabuse. What follows is the main section of a background paper he provided for the international research seminar on alcoholism held in Toronto, May 30 to June 2, 1961.

Alcohol and Other Addicting Drugs Affect Both Individual and State

by Dr. Erik Jacobsen

EACH single individual is generally a member of several groups—his family, his professional colleagues, his neighbours, his work-mates. He can also be a member of several states—his national state, his city, his political party, his trade

union and perhaps the business that employs him. However, both the state and the group are built of single individuals, and the attitude of the societies is a reflection of the attitude of their members although changes may occur but slowly.

The state and the group may look upon the individual with the same eyes, but it may alternatively happen that they disagree, sometimes to a marked degree. The group may encourage when the state condemns, and the state may be indifferent when the group condemns. The state, the group and the individual are three factors, sometimes co-operating and sometimes in conflict, but continuously influencing each other's behaviour and attitude.

The Spirit Around Us All

To these factors, the individual, the group and the state, is to be added a fourth of no less importance, but difficult to describe and difficult to grasp. It is the spiritual atmosphere in which we live, dictating our thoughts and behaviour. It is perhaps related to the instinct that makes a huge flock of starlings turn at the same time with the astonishing precision of military drill. We are under its influence. Why does the same mode of hair cut and dress appeal to a certain class of teenagers on both sides of the Iron Curtain? A special technique in painting may remain absolutely unnoticed at one time and then be hailed and imitated all over the world only a few decades later. Taboos are created and cancelled. Just imagine what the Victorian generation would have said if it were suddenly confronted with a modern bathing beach filled with its great granddaughters undressed in bikinis. The spiritual atmosphere is the vehicle in which we all, individuals, groups and states, are suspended and one that stamps our whole cultural pattern.

The German *"Zeitgeist"* is perhaps the best word for this phenomenon. Although the Zeitgeist is more universal than any state form, it can vary from place to place. It is not the same in the Far East as it is in the Western Hemisphere. In details it may even differ within a relatively limited geographical area. The race problem is regarded differently in the south and north of the United States of America. Everybody is also aware that it may vary from one social stratum to another. The jazz fans in New York's Greenwich Village do not have exactly the same philosophy of life as have their nearby southern neighbours in Church and Wall Street. That the Zeitgeist is fluid and changes from time to time is clear to every school child who has been

taught about the Middle Ages, the Renaissance, the time before the French Revolution and Romantic Age.

Most People Conform

The ordinary individual is generally completely ruled by the Zeitgeist in all his thoughts and behaviour. He dresses and shaves as dictated, he reads the same books and admires the same films as everybody else, he has the same ideals and loathes the same things as do his neighbours. He is not conscious of why he is doing so, but he does it. If he rebels, he is the exception. Perhaps, his rebellion is contributing to the growth of a new Zeitgeist as were the first impressionists or the first young men who grew beards and threw away their neckties.

The state sometimes gets its inspiration from the Zeitgeist. For example, it respects its taboos; if a citizen takes off his pants in a public place, he is fined for indecent conduct. On the other hand the state itself sometimes tries to model a Zeitgeist, especially when the state is built upon a political idea, such as is seen in the totalitarian states. It would be interesting to study the relation between attempts of a political party or a big business concern to influence public opinion, an important part of the Zeitgeist, and through this the Zeitgeist itself. The truth is, perhaps, that it may be possible to accelerate a tendency in a certain direction, but that it is almost impossible to go against the development or even to stem the tide. What have the hatters got out of their efforts to make people again wear hats?

Drugs and the Zeitgeist

Let me now turn to the subject of drugs. The introduction of "Prohibition" has failed in almost every country that has tried it, the U.S.A. and Finland being outstanding examples. These failures were simply due to the fact that too large a part of the population in each country saw no reason why it should not take alcohol. They broke the laws with the best of consciences and consequently created a degree of chaos that forced both states to withdraw prohibition.

There are, however, other and much more complicated ways in which the Zeitgeist can influence drug consumption often much more than is perhaps generally realised. It is a popular conception that the contemplative mind of certain East Asiatic people favours opium smoking, with its induction of passivity and pleasant dreams, which fit their "nature" better than the effects of many other drugs. Although this conceit mostly belongs to the world of the coloured magazines, there may be a core of truth in it. But other factors most certainly

also play a role. The use of marihuana among dance musicians, especially those who cultivate jam-sessions, is both tempting and—at least in the U.S.A.—rather common. It is said, and also confirmed by scientists who have taken marihuana in self-experimentation, that this drug intensifies the feeling for pitch and especially for rhythm. Further, it vigorously intensifies the ecstasy that is the backbone of this kind of music.

Fashions in Drugs

It would be easy to find more examples to show that the preference for a drug is the result of certain cultural patterns and the philosophy lying behind them. But it is still more interesting to note that the preference for drugs can follow the Zeitgeist also within the same cultural group and change within a relatively short span of time. There is also a fashion in drugs. During the middle thirties, when the world was recovering from the crisis of 1929, mental energy and organising power were the most appreciated abilities, and everybody was trying to live up to these ideals in work as well as in play. Then came benzedrine—the pep-pills—also known under many other proprietary names and under the now internationally adopted generic name *amphetamine*. This drug arouses mental energy, abolishes fatigue and induces a special euphoria that makes one feel like a tensed spring ready to release all its hidden energy. In this way, amphetamine was just the drug that fitted into the slogan of that time—"efficiency". No wonder that its use spread like a prairie fire after its properties were discovered, not only in the U.S.A., but all over the world in places where energy and efficiency were appreciated.

Enter the Tranquillizers

The drug is still far from obsolete, it is still both used and misused only to a minor degree. The world has changed. Authors began to rebel, and books, plays and films were showing that life has other aspects besides mere mental gymnastics. The writing of Lin Yu Tang is just one example of the turning of the tide: "It is amazing how few people are aware of solitude and contemplation". ("The Importance of Living"). It is not surprising that he — a Chinese artist of living — wrote books of his particular kind, but it is symptomatic that they became best sellers. Films like "You Can't Take It With You" and plays like "The Death of a Salesman" show the same tendency in a different way. Psychiatrists and psychologists followed the trend with their description of the Paradisian state among the primitive population of the remote island of Okinawa. The

Zeitgeist now changed its slogan from "efficiency" to "deliver us from our hurry and worries". Then it came. Meprobamate (Miltown and Equanil are other names for the same substance) the tranquillizer that, besides inducing slight euphoria, makes us feel that our worries are not worth considering. These "peace-tablets" fell on soil fertilized by authors and essayists. They became a tremendous success, a visible token of which is an annual sale to the value of scores of millions of dollars in the U.S.A. alone.

Japan Energized

Now to the crucial observation. During the years after the Second World War, Japan was rebuilding her destroyed industry and commerce under the supervision of and with help from the U.S.A. In their efforts to out-American the Americans, the Japanese were introducing new "ideals", together with the taste for blended cigarettes and chewing gum. Now it was their turn to use the slogan "efficiency" and at just this time amphetamine became their favourite drug. Amphetamine misuse grew to such an extent that it became a serious problem and necessary to bring the sale not only of amphetamine, but also of all raw material from which it was possible to produce amphetamine chemically, under the strictest possible control. This happened at the same time as the Americans developed an increasing interest for Zen-Buddhism and while the crowded theatre audience on Broadway evening after evening applauded "The Teahouse of the August Moon", in which the Okinawan's taste for simple, yet refined, pleasures conquers the stupid and clumsy attempt of the Americans to be efficient and recast the happy population into their own mould. But time rolls on, and now it is meprobamate that begins to create another drug problem in the land of the Rising Sun.

The "Drugged" State

It can never be ethical for the state to encourage the use of drugs among its members.

Early socialists accused the capitalist state of not regulating alcohol consumption in order to keep the working-class in poverty and thus ensuring a constant reserve of cheap man power. This statement, however, is to be considered rather as propaganda, and it is unlikely that a conscious policy of this kind should ever have been practised by any existing state. But some authors have prophesied that the state might utilize the idea in the future. In his book "Brave New World" Aldous Huxley relates how the state distributes "Soma-pills" to people

in order to keep them happy. A reader with knowledge of pharmacology would describe the effect of these pills as something between that of alcohol and meprobamate, and quite harmless, inducing no side-effects and no addiction. A wonder drug, indeed. Naturally one should be extremely cautious about prophesying, but the prospects for making such a pill are not too good. The higher functions of the central nervous system have tremendous stability and tend to counteract any outside disturbances including that caused by drugs. This means that, after a drug has been given for some time, the central nervous system will become accustomed to it, and that the dosage must be increased to obtain even the original effect. This is habituation. At the same time its inevitable effects on the more primary systems of the body, for example, blood or liver, do not involve the same habituation as those on the central nervous system. The consequence is that, the more doses are increased, the higher the risk is of toxic side-effects, leading to invalidism and disease.

LSD Warfare

However, there are other occasions on which the state might find it desirable to employ psychotropic drugs to obtain advantages over groups or individuals. It has been seriously proposed to use them as war gases. All reports on such matters belong to the top-secret files of government institutions, but some hints have leaked out. For example, one tenth to one fifth of a milligram of lysergic acid diethylamide (better known under the abbreviation LSD 25), a compound that in minute doses produces the most pronounced symptoms, could be spread by explosive shells, dust distribution or other military means over an area occupied by the enemy's army or a group of rebels. For the first 15-30 minutes after the inhalation of this tasteless and odourless substance the victims would notice nothing. Then the exposed people would feel some disagreeable, though not alarming, symptoms; nausea, cold shivers alternating with heat flushes, excessive urine production and other signs of a disturbed function of the so-called vegetative nervous system. After another half to one hour, these symptoms would disappear and an incessant stream of usually quite pleasant dreams would begin. While the population and the soldiers were occupied by these brilliant, beautiful and fantastic, and as a whole far from disagreeable hallucinations, they would be disarmed and their strategic strongholds occupied. When they sobered up after 20-30 hours—without hangover—they would be just as useful as before in a perfectly intact production apparatus. Obviously,

this perspective is extremely tempting for a state fearing internal or external enemies, and doubtless much secret work is still going on in government laboratories with the object of exploiting the strategic possibilities of this or other substances with similar effects. The technical difficulties are many, but should it ever be possible to find a compound effective in small doses, easy to distribute over a large area, relatively innocuous and with the same effect over a large dose range, a new military era would begin—that of psycho-pharmacological warfare.

So-Called "Truth-Serum"

Sometimes the state has to cope with single individuals not with groups. Stubborn criminals or political opponents from our own or other countries are generally silent, and it might be convenient to make them talk. Persuasion leads to nothing, and torture is not always a means, but what about a drug — the "truth serum"? The name is remarkably misleading. It is not a serum, which, as is presumably well-known, is made from human or animal blood, nor does it always provoke the truth. The so-called truth serum is simply a drug by means of which an individual can be lulled into a state of semi-consciousness. During this state he might reveal things that it would be impossible for him to reveal in other circumstances.

Such drugs have been used with success by psychiatrists in the treatment of psychoneurotic patients. According to Freud's theories, certain thoughts with a painful content have apparently disappeared from the patient's memory, but they are still present, deeply anchored in the subconscious part of his brain. Here they form a focus from which his neurotic symptoms spring and from which they are nourished. If the patient can be brought to remember the evil thoughts, their significance (or, rather their relative insignificance) can be explained to him, and he will have a chance of being freed from his psychoneurotic symptoms.

Narco-analysis

Narco-analysis is one method of revealing the subconscious. A drug is slowly injected into the veins of the patient until he reaches a dreamy state in which he still can hear and understand the psychiatrist, but his inhibitions, which hitherto have blocked recollection of painful thoughts, are now abolished, and he is able to talk about them. He may even re-experience a forgotten event with all its horrifying emotional content. The "truth" is uncovered. But this truth is only a relative one; it is still coloured by the patient's psychic construction. Further, if a state

of confidence between the doctor and the patient does not exist, nothing will be revealed. In these investigations, the psychiatrists have used barbiturates, but other drugs have also been employed, for example LSD, amphetamine and alcohol. Scopolamine (hyoscine) is said to work similarly, but the doses necessary to obtain an effect are not safe for the patient.

For obvious reasons the results obtained by similar methods on prisoners — especially political ones — are suppressed, and no reliable scientific literature has been published on this subject. However, if analogies may be drawn from the experiences in psychiatry, it is possible that drugs could help to make prisoners talk, but here the "truth" revealed in these circumstances also is relative. "Confessions" obtained in this way have as little value as, for example, those obtained by means of the lie-detector. Nor can they be regarded as proofs obtained during a properly conducted investigation. Moreover, the use of pharmacological investigation is forbidden in most countries.

The State Against Drugs

The examples given here are examples of the rare occasions on which the state might find it advantageous to use drugs or to encourage their use. For the present the attitude of the state is the direct opposite, and its efforts are concentrated on prevention or at least a reduction of drug consumption. Obviously the state wishes to protect its members against the distribution of dangerous drugs. This task has for long been co-ordinated at an international level. International rules have been drawn up for cultivation of the opium poppy; export, import and retail sale, not only of opium alkaloids, but also of other drugs with similar effects, are strictly regulated. A list of dangerous drugs is compiled and is steadily kept up to date by an international agency.

Such regulations are found even in the most underdeveloped states, but most states go several steps further than what is just required by the Opium Convention. Drugs not belonging to the opium group can only be obtained on a doctor's prescription, alcohol is prohibited or restricted and tobacco taxed. Many regulations must be regarded as resting on sound principles. When a decrease in human precision can produce catastrophic consequences, for example in traffic, it is thought natural that alcohol should be banned. But beyond this point the citizen may feel his personal freedom threatened, and the struggle between the

individual and the state begins. The ruler's personal point of view, linked up with ideas of old taboos, may here be involved. An example is the many bans on tobacco that appeared in the 16th and 17th centuries. Now the ruler's sympathies and antipathies play a minor role, after the disappearance of the great despotic dictators of the fourth and fifth decade of the 20th century, but the influence of the opinions of minor officials can still be traced, for example, in places where smoking is forbidden or permitted. However, a more common attitude is a strictly logical one. In the totalitarian national state and in business concerns, the states within the state, efficiency in work is an absolute essential. A man not at the top of his abilities is of reduced utility. Consequently, drugs that cause indifference, such as alcohol or meprobamate, are unwanted and therefore banned. A natural question then is why drugs, such as amphetamine, which increase efficiency, are not encouraged in such states. In fact they are, for example, among soldiers, but even if they increase working power for a short period, their continued use will lead to a disease that in the long run does more damage than is gained at the beginning.

The Individual vs. the State

This leads us to the second point. In the welfare state, disease is no longer a private matter. When the state pays for treatment, it is interested in preventing disease. Not all diseases can be prevented, but at least it is possible to forbid drugs that may give rise to disease. Almost all drugs cause disease when they are misused, but as some of them are also important in medicine, a compromise is necessary. It is comparatively easy to handle a new drug. If it can only be obtained in a pharmacy on a doctor's prescription, it is almost certain that it will only be used for healing sickness. With drugs such as alcohol and tobacco, which were known before the pharmacy was invented, no rule about prescription can limit their use, and other measures must be taken if the state wants to prevent their misuse. The means to regulate the consumption of these two drugs are numerous and the description of how to do so fills libraries. Everything ranging from total prohibition to mild sale regulations, has been tried. But whatever is done by the state will be a nuisance to many citizens who find their personal freedom infringed at this point. Here we have one of the main fronts of the eternal battle between individual and state.

One particular kind of regulation brings us face to face with a dilemma. In many countries alcohol and tobacco are heavily taxed. Beyond doubt the consequent artificial increase in price is a high barrier against misuse. When the prices of alcohol in 1917 suddenly were increased 4 times in Denmark, one consequence was that the number of cases of delirium tremens in Copenhagen decreased from about 300 to less than 10 per year. Clearly the tax money amounts to a tremendous income for the state. One third of the whole income of the Danish State is yielded by the taxes on alcohol and tobacco, a sum perhaps 50 to 100 times higher than that spent on the treatment of alcoholism and lung cancer. When the state has become economically interested in the consumption of drugs, it is difficult for it to be objective and to consider exclusively the welfare of its citizens.

The Group and the Drugs

Non-sectarian groups will generally tolerate the use of drugs among their members as long as such use does not bring the consumer's behaviour in obvious conflict with what the group considers decent. For example, a physician who is a morphinist can be an appreciated member of the society of his small town, perhaps even after the moment when his addiction has brought him into trouble. Most groups are entirely indifferent to a moderate intake of alcohol. It might even be that alcohol consumption is part of the group behaviour, so that those who abstain place themselves outside it. The man who refuses to drink a beer when his fellows are doing so may well be regarded with some suspicion even if his group — for example his mates at his work-place — as a whole consists of only moderate drinkers. Heavy drinkers go together. They find each other over long distances; they have a common language and there is a kind of freemasonry among them. Alcohol is one of the most group-stimulating of drugs. But groups can also be formed around the use of drugs that are a long way from facilitating group feeling. Morphinists, heroinists and cocainists do not enjoy their drug intake communally; they are linked together in a common "vice", and this indeed is one of the most group-stimulating factors in the world. An addict of one of these dangerous drugs has a strong tendency to join a group of other addicts; if he cannot find other addicts, he may try to create some. The social contamination due to the drug habit is one reason why the state tries by every means to

control drug consumption and limit dangerous drugs.

The individual is psychologically much more dependent on his group than on his state. Extremely few, if any, human beings can exist without belonging to at least one group and most feel the need for several; how many, depends on dwelling place and social status. For example, a newcomer will attempt to join an already existing group or form one around him. His feeling of loneliness will most certainly overwhelm him if he does not succeed. The many suicides among immigrants is a serious and extreme consequence of this fact. The intense happiness of belonging to a group and enjoying the company of one's fellow men and feeling their sympathy cannot be underestimated, and many people take drugs just because they facilitate or replace group feeling.

onvivial Alcohol

Only a few drugs can stimulate group feeling. Alcohol is the best known and the most widely used. We all know that a number of people who have in other circumstances little in common can for a time be moulded into a single convivial group while under the influence of alcohol. The property of alcohol is widely applied in all kinds of gatherings, from cocktail parties to banquets. After large doses, the millions are Umschlungen and songs like "The more we are together", "Trink, Bruderlein" and "Dans une cave" express the feelings of merry drinkers. But it is far from necessary that people should actually get drunk; group feeling is stimulated even by comparatively small doses of alcohol, as for example is seen at the "Stammtisch" of the German Bierstube, at the zink-desk of the French bistro or in an English pub. In the early Christian days the use of wine played a much bigger role than today. The partakers of the Holy Communion drank wine to excess—most likely in order to stimulate their feeling of community with the congregation. In any event St. Paul found reasons to warn against exaggerated wine consumption on such occasions.

Many alcoholics have begun to drink because of their difficulty in making contact with their fellow men. Only under the influence of alcohol is their shyness overcome, and they are then able to feel the equals of other members of the group. An alcoholic under treatment must leave his old group of fellow-drinkers. If he cannot join a new (and abstinent) group, the treatment is doomed to failure; still worse, his loneliness may result in psychosis or suicide.

There are few drugs besides alcohol that can be used to stimulate the group feeling. In certain Latin American Indian Christian sects the solemn Service is linked with the intake of peyote. This drug consists of cactus buds containing mescalin and other compounds with effects similar to those of its active substances. Its consumers have all their sensual perceptions disturbed. Colours are perceived more clearly and brightly than normal; the shapes of observed objects are seen as if carved by a master sculptor's hand. Everything is felt to be different, including ones own limbs and body. Inspired by these strange experiences (described for example in Aldous Huxley's "The Doors of Perception") the participants feel intensely their identity with the rest of the group, a true orgy in the original Greek sense of the word. A more profane use of peyote is made by certain sophisticated circles of New York bohemians who gather in parties in order to consume it. In this connection the smoking of marihuana cigarettes by dance musicians ought again to be mentioned. The common inspiration and infectious enthusiasm in a group of instrumentalists are to a large extent an expression of a group feeling that is intensified by marihuana.

Many drugs are without influence on group feeling. Amphetamine makes people talkative and ought to facilitate a certain degree of contact, but it does not induce the feeling of universal benevolence so intensely sought by some; moreover, the art of listening is just as important as eloquence.

Group-Replacement Effect

Finally, we have drugs that loosen the individual's contact with the outer world and are group-antagonising in this way. Most of the drugs that induce vivid dreams or hallucinations are not suitable for consumption in company. Nothing is less important for the opium smoker or the hashish eater than the presence of other people; he couldn't care less about what they are doing or what they think about him. The new unrealistic world that has appeared within his brain, filled with glamorous thoughts, dreams and images, is sufficient for him and can therefore replace the group and the sympathy of his fellow men. An effect of this kind might be called a group-replacement effect. Not only are drugs such as morphine and marihuana replacing, but the same might also, paradoxically enough, occur with, e.g., alcohol, in spite of the fact that alcohol as a rule stimulates group-feeling.

Amidst the flowers from a jar
I lonely pour my wine, without my friends.
Against the brilliant moon I lift
my cup, inviting it to feast.
Now with my shadow we make three,
Although the moon can't drink and
my shadow is clinging to my body,
we will make a party
and celebrate the merry spring.
I sing, the moon seems swinging to and fro;
I dance, my shadow is teasing me with gestures.
As long as we are sober we rejoice in our company,
And we must part when we get drunk,
Regard the distant milky way
And feel the longing for it. —*Li Tai-Po*

There can hardly be expressed more clearly—or more beautifully than in these more than 1250 years old words—how the intake of a drug is able to replace the group and to induce the cosmic feeling that is the desire of every poet. Many other drugs besides alcohol could make people feel they are poets. It is without importance to them that few only can give expression to such feelings.

hort-Cut From Reality

We as members of the human race, all have the desire to escape from anything we feel to be dull daily routine. There are many ways of doing this. Art, dance, discussions, gardening, literature, love, music, political meetings, science, sport, stamp collecting are a few examples from the thousands of ingenious games invented to make a man feel that he is made for more than the production and consumption of his daily bread. He can get the same feeling from drugs. In contrast to many other means of escape from reality, drugs do not require active participation by the consumer. The cosmic feeling and the dreams come by themselves, and nobody needs to work to get them. The individual takes drugs because they are an easy short-cut and a safe (although not always healthy) way of escape from reality. Which drug is chosen depends on the mental make-up of the consumer and also how he is influenced by the indefinable Zeitgeist.

ocial Contagion Is Important

How society in the form of groups or states looks upon drug consumption by its individual members is largely determined by the character of that society. The attitude of

the individual's surroundings, here defined as the grou depends on habit, education, culture and the gener behavioral pattern of the group. The individual's deep desi to enjoy the company of his fellow-men has been thorough discussed. If he feels lonely or if he has difficulties in makin contacts he may take to drugs in order to compensate h loneliness and replace the group. In its turn, the group ma lead the individual to take drugs if the group behaviou includes their consumption. There should be no need t emphasize again that this social contagion is most importar in the development of addictions.

Turning to the state, the problem differs with the typ of state. The *totalitarian state,* the ideal of which is to moul Zeitgeist, group and state into one entity, is in principle agains the use of drugs, at least to excess. Its citizens must be health and maintain their capacity for work. But, more importan they must be so happy and filled with zeal to serve the stat that it is unnecessary for them to take drugs. Certain totalitaria states once claimed that alcoholism, morphinism and other ou ward signs of exaggerated drug consumption were unknow within their territory. Events have later shown that this state ment was due to wishful thinking rather than a statement o fact.

For sheer economic reasons the *welfare state* is agains drugs. It is cheaper to ban a drug than to have 2-3% of it consumers ill or chronic invalids.

The state that pays more attention to the individua freedom of each of its inhabitants, let us call it the state o *enlightened democracy,* has not only practical problems but also principles to cope with. It is extremely difficult to strike a balance between the interests of the individual and the state On one hand the individual must be protected against his own weaknesses, but on the other the state must not be a nursery home in which everything with the slightest possible potentia danger is forbidden.

When and where the state should use drugs on individuals, for example by use of "truth serum" or for general doping with a coma-like drug, will be determined by the ethical principles of its rulers. The more that individual rights—even those of criminals—are respected, the more will use of pharmacological pressure be rejected; the more stress laid on the interests of the state, the more inclined will the state be to use all possible means, including drugs, to protect its interests. ▲

FOUNDATION NEWS . . .

• The second **international research seminar on alcoholism** to take place in Toronto was held May 30 to June 2 at the Faculty Club, under joint sponsorship of the Alcoholism and Drug Addiction Research Foundation and the Department of Psychiatry, University of Toronto. A limited invitation list, closed sessions, and informality combined to produce a maximum exchange of ideas in the three full days of small-group discussions.

Visiting delegates were: Dr. W. E. Anderson (psychiatrist, University of Manchester, England), Dr. Dugal Campbell (psychologist, Queen's University, Kingston), Dr. Oskar Diethelm (psychiatrist, Cornell University, New York), Dr. George C. Drew (psychologist, University College, London, England), Dr. Pierre Fouquet, psychiatrist, Clinique de Versailles, Versailles, France), Dr. Leonard Goldberg (pharmacologist, Karolinska Institute, Stockholm, Sweden), Dr. Joan K. Jackson (sociologist, University of Washington, Seattle), Dr. Erik Jacobsen (pharmacologist, Dumex Limited, Copenhagen, Denmark), Dr. Gunnar Lundquist (psychiatrist, Longbro Sjuckhus, Stockholm, Sweden), Dr. Norman McCallum (director, Forensic Science Laboratory, University of Melbourne, Victoria, Australia), Dr. Hugo Solms (psychiatrist, Universitatspoliklinik, Bern Switzerland), Dr. George Sturup (psychiatrist, Herstedvester, Copenhagen, Denmark), and Dr. Heikki Waris (sociologist, Finnish School for Alcohol Studies, Helsinki, Finland).

• Three new staff joined the Foundation in June—two clinical and one educational.

Miss Helen Lazarski, R.N., former clinical teacher of the Kingston General Hospital, has been appointed head nurse of the Foundation's Toronto clinic.

Mr. Imre Nemeth, M.S.W., formerly of the John Howard Society in Toronto, and Verdun Protestant Hospital, Montreal, has been appointed to the social work staff of the Foundation's Toronto clinic.

Miss E. Jane Rittenhouse, former executive director of the Ottawa branch, Canadian Mental Health Association, has been appointed education officer in the Foundation's head office education staff.

IN CONFERENCE . .

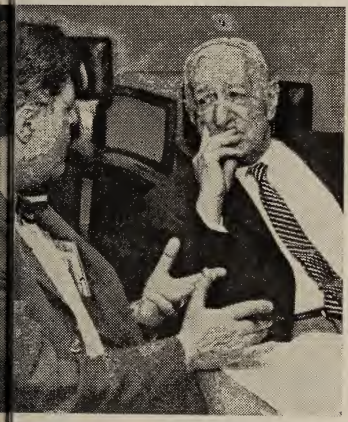
Dr. Jackson *Dr. Waris*

Solms, Fouquet, Lundquist, Ga

Dr. Fouquet, Mr. Archibald and Dr. Goldberg►

Dr. Solms *Mr. Aharan*

Waris, Sturup, Jacobsen



Mr. Archibald Dr. Jacobsen Dr. Waris

◄Dr. Goldberg with Dr. Jellinek

Dr. Appleby Dr. Lundquist

—Photos by Wm. J. Wacko

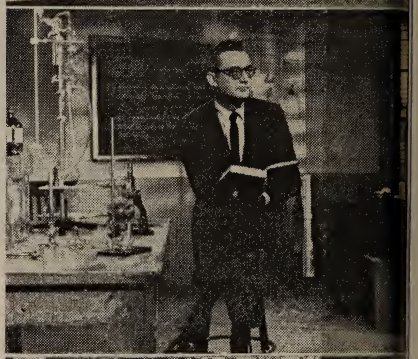
"It's Best To Know"

STARRING Steve Allen of television fame, a new motion picture for use in high school alcohol education has just been completed in Hollywood for the Alcoholism and Drug Addiction Research Foundation of Ontario and the Alcoholism Foundation of Alberta. Its title is "It's Best To Know."

In it Steve Allen talks straight from the shoulder to young people, and three dramatic sequences illustrate very commonly encountered social situations involving drinking. The message is: you don't have to drink to have a good time; but if you intend to drink it's best to know first what alcohol does to everyone's judgment, coordination, vision and behavior.

The film runs eight minutes. It was produced and directed by James Swackhammer of Swackhammer - Gordon Ltd., Toronto, and filmed in the Red Skelton Studios, Hollywood.

The cast.



The star.

Office situation

Social situation.

lind, Body, Society, and Alcohol nter-related in Causing Alcoholism

BY OSKAR DIETHELM, M.D.

IN ATTEMPTING to obtain an understanding of etiologic factors in alcoholism two points are of fundamental importance. First, alcohol affects an individual who is a *biosocial* organism. This statement stresses that biological and social aspects are integrated in a unit affecting each other. In current thinking, biologic means *psychobiologic, physiologic* and *psychologic* functions constantly related to each other. The last point included is the acceptance of individual differences in reactions to alcohol. Second, alcohol affects the individual in his relationship to the social environment, including the family, occupational and recreational groups, the community in which one lives.

All these aspects must be considered if one intends to investigate the factors which bring about the patient's alcohol problem. Although a study of etiology deals with the primary causes for alcoholism, the problem is still so involved that it is most difficult to single out the effect of the chronic intoxication on the individual and his environment. It is, e.g., unclear which factors, because of physiologic damage, might be essential in the final clinical picture which we call alcoholism.

lany Unanswered Questions

A broad study must include the understanding of alcohol as a drug, its effect on the body and its destruction, its psychologic, psychopathologic and social effects, and its cultural implications. We do not know whether physiologic damage leads to dependence on alcohol or whether psychologic factors lead to psychologic and later, physical damage. If a physiologic or psychologic damage exists, will it be permanent or does permanency relate to additional psychologic factors, e.g., anxiety, resentment, or expectancy of a desired effect associated with guilt?

These introductory remarks illustrate the complexity of the

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problem which we are discussing. They urge us to find limited goals in well-defined areas, and to proceed systematically. The need for collaboration with investigators from other fields is obvious if one wishes to include in the study the patient, and not merely separate physiologic, psychologic or social effects. In discussing the various aspects in the special areas outside psychiatry, I shall point out questions which trouble us as psychiatrists, and leave it to the experts in the various fields to elucidate on present knowledge and avenues for clarification and investigation.

Intoxication Not Yet Understood

Little is still known about the effect of alcohol on the body and what actually takes place. Although there is a considerable fund of knowledge referring to the metabolism of alcohol we do not know much about resulting intoxication. This lack of knowledge is troubling the investigator as well as the clinician. It has led to much empiricism and claims little supported by evidence, e.g., that thyroid compounds or ACTH will remove the toxic effect rapidly.

Studies are needed to determine physiologically and pharmacologically the findings during periods of heavy drinking and long periods of abstinence. Studies before and during alcohol consumption would demonstrate the effect of alcohol which might be increased or diminished by various factors.

Susceptibility Varies

Another unexplained observation relates to the varying degrees of susceptibility to alcoholic intoxication in different individuals and in the same individual under different conditions. Most interesting to the psychiatrist is the role of emotions. There is considerable evidence that some individuals are resistant to alcohol when they feel mildly depressed. Others become more readily intoxicated in states of anxiety. However, these are casual observations of clinicians. Little effort has been expended by psychiatrists to study the emotions involved before the patient starts drinking, and to offer the physiologist and pharmacologist an understanding of the emotional setting in which he administers alcohol (I shall return to this topic when I discuss our recent experimental findings on acute alcoholic intoxication). With increased physiologic and psychologic knowledge of the relationship of drugs to emotions, e.g., chlorpromazine, new avenues for research might be opened

In this connection it may be appropriate to mention the importance of the person's attitude to impending consumption of alcohol. The expectancy of certain effects of the alcohol will facilitate its occurrence. In the presence of a placebo administered intravenously, the fact of the placebo being unknown to patient and psychiatric observers, physiologic and emotional effects resembling alcohol were observed by both subject and observer. Tolerance, intolerance and desire must be investigated if one carries out the experiment of producing mental impairment in the presence of given concentrations of alcohol. It is unknown in which way a changing tolerance is related to changes in physiologic-psychologic desires or in biologic need. The difficulties become even more involved when the question of habituation and addiction are raised.

Rats React Like Humans?

The claim that dietary deficiency in a well-balanced diet may occur because the patient has an unusual need for some of the dietary essentials cannot at present be accepted or rejected because one has not considered the emotional factors present and the individuality of the subject under study. Observations on rats, whether they indicate the role of dietary deficiencies or an effect of thyroid compounds on appetite for alcohol, are meaningful and stimulate psychiatric interest. Their significance in human beings is still unclear.

Candy Dandy?

In recent years the relationship of alcohol to vitamins in food has been stressed. Previously it was stated in literature that some alcoholics are able to abstain from alcohol if there is a ready accessibility of carbohydrates, especially in the form of candy. Gradually these clinical observations have become subjected to a scientific scrutiny.

The role of catecholamines, to mention another interesting investigation in the etiology of alcoholism is obscured by the influence of emotions on catecholamines. Their presence in the blood of patients experiencing strong emotions such as anxiety and resentment is known.

The role of aldehyde has been somewhat clarified but has given rise to many more questions, relating to the clinical picture of hangover and its significance.

It might be useful to reconsider some of the discarded findings of older physiologists. To the psychiatrist it is still an unanswered question whether alcohol as such is the only

toxin to be considered or whether the addition of special ingredients is also important. In an alcoholic drink, the toxic effect may be related to alcohol and to potentiating agents which of themselves may not be toxic. In liqueurs, e.g., fusel oil and alcohol are the toxic factors. Korsakoff's psychosis has been related to drinks such as gin, vodka and liqueurs. Delirium tremens has, by some, been related to strong drinks and dietary deficiencies while others saw a significance in the type of alcoholic beverage used. It is also likely that the application of new biochemical and physiologic knowledge to some of the earlier observations or claims might prove to be valuable. The possible effect of alcohol on the brain of the fetus in various stages of development is unknown and needs to be clarified, as well as the significance of genetics. The accepted claims of the older authors have been shaken severely by more recent studies, which, however, have not offered satisfactory answers to clinical observations of the descendants of alcoholics.

To summarize: Many problems present themselves to the physiologist, biochemist and pharmacologist with regard to the metabolism of alcohol and its effect on the healthy and sick organism physically and psychologically in different phases of life development. The influence in a changing physiologic and psychologic milieu is not known. The effect of drinking patterns and the addition of various ingredients to alcohol has not been considered. Environmental factors may exert a marked influence in experimental work, e.g., the toxic effect in the sober hospital or laboratory atmosphere may be different from that in a congenial bar or in the presence of a hostile or submissive wife. Any experiment must be well defined so that as many factors as possible can be recognized and evaluated. In our physiologic experiments we measure the complex end result of many factors. Some claim, therefore, that we still need to know a great deal more about the effect of alcohol before we can study the etiological factors in alcoholism. To put it in other words, *let us study first what alcohol does* IN *the person before we study what it does* TO *the person.*

Psychology and Psychopathology

During the past 50 years clinical and experimental psychologic studies have contributed to an understanding of the effect of alcohol on psychologic functions. These findings, however, have been of limited aid in psychopathologic studies. Many of these studies suffer from the fact that isolated functions were

most carefully investigated but the effect of alcohol in changed psychologic and physiologic settings was usually not clarified by repeated investigations.

ere Are Different Forms of Alcoholism

The contribution of psychology to a clarification of the etiology of alcoholism has been very limited. This fact is not surprising because the psychiatrists have not offered well defined questions and problems. Projective experiments, e.g., have been used freely to obtain answers to broad questions, and were given to patients with an ill-defined or unspecific alcohol problem. The findings of Rorschach were used as an important guide, and it was overlooked that he studied only a few alcoholics of the deteriorated type. Little attention was paid to the possibility that there are various clinical types of alcoholism and that they occur in different, well-defined clinical settings. Psychologists and psychiatrists often present a concept that alcoholism is a unit reaction. This mistake is unfortunately not surprising because a considerable group of psychiatrists argues in favour of unit psychosis — a concept which was acceptable a hundred years ago, was then rejected, but has of recent years become of interest again. This time, these psychiatrists are going a step further than those of the 19th century — they not only claim that all psychoses belong to the same unit, but also state that it is not possible to separate pathologic and non-pathologic behaviour. *The tendency to look for the same etiology in all forms of alcoholism cannot lead to fruitful results.* In addition, in these studies little thought is given to the consideration of other factors supplementary to alcohol. Even if there were a common denominator, additional factors may lead to specific constellations which may lead to pathologic reactions.

nditioning the Emotions

The role of emotions has been studied intensively and the importance of certain emotions (anxiety, tension, resentment, and hostility) singled out. There seems to be a close connection between the conscious, but not recognized emotions and alcohol consumption. It is possible that the need for alcohol persists although the causes which led to the disturbing emotions have been removed. The point is therefore made that one deals with conditioning of the emotions.

Much emphasis has been put on experimental studies in alcoholics following the pattern which has been found interesting in patients with drug addiction. As it happens, most of the

studies published were done on patients who were poorly organized, psychopathic personalities. It has been well known since the turn of the century, and increasingly noted since then, that many of these types of personalities are able to react with far-reaching psychopathologic and, to a lesser extent, physiologic reactions, which would not occur in psychoneurotic individuals. This fact has been well established in toxic reactions, whether they be drugs, infections, or other toxins. Findings in such persons are most difficult to evaluate psychopathologically.

An "Alcoholic Personality"?

Insufficient evidence is available to support the claim that specific personality types predispose to alcoholism. It is questionable whether the study of personality patterns can contribute to a direct understanding of etiology, but the findings may be of value for orientation in physiologic, pharmacologic and sociologic investigations.

At various times, current psychopathologic theories have been applied to an explanation of the etiology of alcoholism. The criticism seems valid that findings in carefully studied cases have been generalized, e.g., the dynamic importance of homosexual factors, of oral factors, of aggression and hostility. One cannot be satisfied with merely establishing such findings, but one needs to investigate why emotions and psychodynamic factors lead to drinking.

Alcohol Combined With Other Drugs

Psychiatrists would like to know more about other ingredients in the alcoholic beverage used by their alcoholic patients. The biologic and psychologic effect of alcohol combined with drugs is little understood. The Apache Indians add tobacco to a very intoxicating alcoholic drink. Whether this drink is used widely because of the desired effect of rapid intoxication, or because of the ready availability and inexpensiveness of the home brew, or because unknown specific factors play a role, is unclear.

Previously it has been stated that the emotional setting is of importance with regard to the effect of alcohol. In one of our patients to whom my colleague, Dr. Peter E. Stokes, administered 100 cc of alcohol intravenously, the patient reacted within seven minutes after the infusion had been started with marked dysarthria, incoherent speech and was in a state of excitement which lasted 15 minutes. This behaviour, for which he had amnesia, resembled that of previous alcohol intoxication in bars.

The patient's blood contained 349 mg. % of alcohol. Two days previously the patient had received 100 cc of alcohol intravenously, and during the infusion (15 minutes after the onset), the blood contained 156 mg. % of alcohol. He showed no sign of toxic effects in his behaviour at this time. Toward the end of the infusion, which took 36 minutes, he felt drunk and said he might not be in full control of himself, but showed no other signs of behaviour disorder. His blood contained 290 mg. % of alcohol. It might be mentioned that on the day of the excitement, the alcohol had been given in a high concentration which made it possible to give him the amount in 17 minutes as against 36 minutes on the previous occasion. The interesting point is that the second infusion was administered when the patient was in a state of acute anxiety related to a telephone conversation 40 minutes before the experiment was started. The psychopathology in the presence of concentration in a range between 250 and 350 mg. % is little known. From such a point of view the patient's pathological behaviour cannot be understood satisfactorily. It is also unknown what role ever-present emotions play in tolerance to alcohol. However, we recognize that unusual emotions may affect susceptibility to alcohol. The interesting point is that the second infusion was administered when the patient was in a state of acute anxiety, related to a telephone conversation 40 minutes before the experiment.

Acute Pathological Intoxication

The above case brings to mind the concept of acute pathological intoxications. In textbooks of psychiatry it is assumed that one deals with a physiologic basis for them. Others state that these reactions occur in poorly organized psychopathic personalities, in disorganized schizophrenics, in epileptics and in patients with cortical damage. Nobody has proposed a common denominator or an etiologic explanation.

Blackout Phenomenon

States of amnesia (blackouts) deserve careful investigation. In our own findings, the emotional status and the amount of alcohol played a role as well as psychodynamic factors. There are indications that several types of amnesia occur with psychologic and physiologic factors. Physiologic investigations have not been carried out sufficiently, e.g., electroencephalographic studies. Serotonin and bradykinin findings were difficult to evaluate. Psychiatrists consider the pathologic states of alcoholic

amnesia important. Some authors state that they are indications of a serious progressive deterioration with cortical damage, while others merely consider their occurrence as a sign of serious chronic alcoholism.

Hallucinations

It is at present accepted that auditory hallucinations are related to an existing schizophrenic illness. No satisfactory explanation has been forthcoming for visual hallucinations. In the last century it was quite common that the acutely intoxicated person hallucinated a black dog following him through the dark street. This hallucination may have been related to the type of alcoholic beverage, to the amount consumed, to cultural factors and to expectancy of the hallucination by the intoxicated person. The common visual hallucinations experienced in a delirium tremens are not explainable at the present time. (The tactile hallucinations are probably related to mild neuritis but possibly also to sexual unrest in some patients or other unknown factors).

The behaviour of an intoxicated person may depend on the amount of alcohol consumed, on the speed of drinking, on psychodynamic and social environmental factors, on the person's physical status, and on social customs and expectancy.

A Habit or A True Addiction?

Whether physiologic or psychologic factors lead to the destructive desire, conscious or unconscious or essentially biologic, to a need or a psychologic habit formation, or to true addiction, is not clear. The lack of true tolerance and the frequency of decreasing tolerance in progressive alcoholism as well as the lack of marked withdrawal reactions argue against addiction. (In recent years the controversy of delirium tremens occurring in the setting of abrupt withdrawal has been revived. In publications, there is frequently no clear description of the psychopathology offered. Not every delirium in association with alcoholism is a delirium tremens. There may be other toxic or physiologic factors which must be evaluated). Experimental studies of conditioning have thrown little light on this factor but it is difficult to obtain a clear picture in literature. The animal experiments on food selection, including alcohol, are most stimulating and deserve to be continued energetically with emphasis on the emotionality of the rat, on the different reactions by different strains and the use of different animals e.g., dogs and rhesus macaque.

It is difficult to discuss the role of placeboes under one

one heading. Chemical and physiologic aspects are important, as well as psychologic ones. In addition, the role of the experimenter and the influence of the immediate environment have considerable influence on the subject. These difficulties should not prevent us from using placeboes but should make us hesitate to evaluate findings too readily.

al and Cultural Implications

In the foregoing, there has been a continued emphasis of the importance of environment on biologic, psychologic and psychopathologic conditions. There are some points which need to be re-emphasized or elaborated. The social factors have been studied in selected occupations years ago, on those employed in breweries or in inns; in recent years, on seamen and soldiers. Additional emphasis is put on the personalities involved to elucidate their sociologic vulnerability. From such a point of view, male and female alcoholics have been explored.

Drinking customs have been studied in rural and urban districts, among the poor and the well-to-do, the poorly educated, and the students in colleges and universities. National differences have been singled out. There is a great deal of valuable material. Much of it deserves to be reviewed with more modern methods. To further the etiologic understanding, a more inclusive study, with consideration of physiologic factors and status of health, is frequently indicated and repeat studies seem therefore desirable.

dy of Young Drinkers Needed

Finally, much attention has been directed to youth and family. Unfortunately, psychologic and psychopathologic studies of both of them have been undertaken only in recent years, and knowledge is deplorably insufficient. In young persons, the toxicity of alcohol is unsatisfactorily understood. In this age group it seems especially important that one determine the toxic effect on behaviour—how much in the behaviour is uncontrolled or controlled and along which lines.

The attitude of the group influences toxic behaviour greatly. Behaviour which is unacceptable in one's group is significant, whereas disordered behaviour, stimulated by the environment, may be acceptable. Broad cultural attitudes are important. On such a basis one can understand the behaviour and the psychopathology of the Irish in Boston and New York at the turn of the century and one does not need to look for the racial Hibernian factor.

Similar cultural factors are recognizable in the toxic stat of the American Indian. No special susceptibility to alcoh could be discerned in a group of Apaches studied by the autho

Ethnic Factors Little Understood

The interestingly low number of alcoholics among Jews well recognized. Social and cultural factors might offer sati factory explanations. On the other hand, one needs to keep i mind that ethnic factors are as yet little understood.

A study of Chinese in New York's Chinatown gave su port to the theory that the low incidence of alcoholism relate to social and cultural factors. An interesting observation wa that alcoholism and gambling seemed to be in inverse relatio ship, but no psychologic studies have been undertaken to clari this point.

The Course of Illness

There are many observations on changes in the body wit prolonged excessive use of alcohol. Very little knowledge ha been added in neuropathology. Newer techniques should b applied and investigations with the electronic microscope en couraged.

Little is known yet about neuropathologic changes i delirium tremens, in Korsakoff's disease, in alcoholic deterio tions. As was mentioned previously, the influence of alcoh alone cannot explain the pathologic changes and the psych pathologic phenomena.

It is doubtful that liver damage always occurs in prolonge alcoholism. The patients who seek help for liver damage a usually patients who have been excessive drinkers. Many o them can stop drinking when urged to do so by the physicia These patients are different from a vast group of chron alcoholics who cannot control their need for alcohol.

Better Life Histories Will Help

There is a dearth of careful studies of individual alcoholi over a long period of time. Life histories with careful investig tion and recording of physical, psychologic and social data a much needed to clarify the many factors involved. It mig support the claim that all former alcoholics remain vulnerabl be it on a physiologic or psychologic basis. On the other han it might demonstrate that this broad statement is too gene and that some persons can later maintain controlled drinkin Such absolute health restrictions may be wise for a physici

but cannot be accepted by the investigator.

Periodic drinking cannot be explained satisfactorily by a cyclothymic personality and thus be related to a manic-depressive illness. Another explanation assumes cyclical physiologic phenomena or endocrinologic factors. In some patients, increasing resentment may affect physiologic functions and be alleviated through a period of excessive drinking. This kind of periodic drinking seems to be different from the cyclic type. In other patients, one observes long periods of abstinence, followed by a period of months or years of alcoholism and even permanent chronic alcoholism. Attempts at investigation of periodic drinking must include the study of drinking and non-drinking episodes.

At various places there have been raised points which can only be studied well if the patient's course of illness can be evaluated. Problems already mentioned are changes in tolerance and at what stage a patient becomes capable of developing a single, or repeated, attacks of delirium tremens, a Korsakoff psychosis or an alcoholic hallucinosis. If it becomes established that an auditory hallucinosis is related to schizophrenia, it raises the question why such a hallucinosis occurs only after prolonged alcohol abuse. Might other drugs produce the same kind of psychopathologic reaction?

The role of acetaldehyde has become recognized as important in hangovers, but it is not considered the sole factor. During prolonged alcoholism, hangovers may change in character and intensity. Whether it be related to the persistent alcohol intake or to resulting physical changes deserves considerable thought.

ferent Effects at Different Ages?

Studies on the rate of disappearance of alcohol from the blood and the rate of metabolization in the body at different periods of an individual's life are missing. The results of these investigations might throw light on alcoholism which becomes apparent between the ages of 40 and 50 in individuals who have been drinking regularly, but with good control, and not to excess.

In the study of a person's life, sociological and cultural changes must be considered as well as changes in the mode of living, of diet, of types of drinks, of attitude to alcohol, of physical and psychopathologic illnesses, and of aging.

Investigations into the etiology of alcoholism will always be complicated because the problem is complicated. ▲

The Last Word by Dr. E. M. Jellinek

SOMETHING significant has happened at this meeting . . . It has produced solid grounds for the hope of a true multi-disciplinary approach to this problem of alcoholism. We have talked for years about this multi-disciplinary approach, and there have been books compiled in which representatives of various branches of science wrote about alcoholism out of their experience and their training; but even the editors have not been able to tie these things together. One has always left such a book with the feeling that alcoholism is *either* a social problem, *or* a psychological problem, *or* a physiological problem. Here at this meeting, however, I got the feeling that it is possible after all to have a multi-disciplinary approach and to integrate all these things into a meaningful whole.

Much Rethinking, Some Agreement

Evidently much re-thinking has taken place, not just here in these few days, but over the past couple of years. That people have been revising their ideas in the light of new facts has been reflected here very strongly indeed. There was even a consensus achieved on at least some questions—though of course not on all.

For instance, there was a consensus on the matter of initial craving. I think we all agreed that there was no craving at the very start of taking a drink; that is, that there is no physiological anomaly which brings a person to his very first use of an alcoholic beverage.

Alcohol is Important

Second, there was a very definite recognition that alcohol itself plays an extremely important role in alcoholism. It is really ridiculous that one has to emphasize this. But if you go over the literature of even a few years ago it is astonishing how the various students of alcoholism disregarded the substance which the alcoholic uses. Here we have had, I would say, a consensus on the fact that alcohol plays a tremendous role in alcoholism.

There has been, also, quite some agreement upon the fact that there is a very great difference in what happens in a drinking bout and what happens in the resumption of a drinking bout. (By the drinking bout I mean taking up the

first glass today and then going over it to the second, sixteenth and twentieth glass; and this is an entirely different mechanism from that which leads the person three, four, or six weeks later, to resume the bout.)

We even approached some agreement on this rather elusive concept of tolerance.* At least we tended towards an agreement.

There was also some indication that the terminological chaos is coming to an end. I would say that there is today some terminological insecurity, but I don't think that we can talk of the chaos any more. Of course, in international gatherings where a word has a different meaning in another language there will still be some misunderstanding. But at least within a given country there is a tendency to use a certain terminology.

ugh to Navigate By

I would also like to say that my feeling, which I have had for many years, was reconfirmed in this meeting—that too many of us have the tendency to deplore our lack of knowledge about alcoholism and like to stress very strongly that we don't know anything. I would like to say on this point that anybody who would know all that has been called knowledge about alcoholism would know a very great deal indeed. Certainly there is much more that we don't know than that we know, but what we know is of no mean volume. It is important. And it is sufficient, at least, to navigate by. Throughout the history of mankind we have been practically content to rely on certain things as if they were so. Our ancient navigators navigated wonderfully in spite of the fact that they presumed that the sun was turning around the earth. That was an "as if" principle, and they got along quite well. Now, I don't say that one should be content with navigating on an "as if" basis, but one should do that until one has a much better basis, and one should at the same time make every effort to get to that better basis.

Many "Researchers"

When I spoke here about some degree of consensus, some approach toward a common terminology, I wasn't kidding myself by any means that there was a whole regiment, or army if you like, of research workers who would not feel this way, who

**There was agreement that the term tolerance should be used only with reference to the blood alcohol concentrations at which psycho-physiological functions show changes, i.e., tolerance must be viewed in terms of thresholds.*

would still be floundering. Some twenty years ago I wrote th
anybody who stumbles upon a few case histories of alcohol
feels compelled, and feels that he has a claim, to write abo
alcoholism. That is a very unfortunate thing. We have,
a matter of fact, not too few research men but too many, wh
in ordinary good American slang are "gumming up the works
Unfortunately, on the North American continent we seem
have a kind of formula by which we say that eleven so-
research workers make one good and able one, or that
dwarfs make a giant. That, of course, has wrought havoc wi
our alcohol literature, as it has wrought havoc in all branch
of research, not only in alcoholism. And just because resear
reports appear in a highly respectable journal one has to ta
account of them, which is rather deplorable. Here in this ve
small meeting we have had the great good fortune of workin
not with those artificial units of good and able research worke
but with the good and able research workers themselves.

I have also felt, of course, that in a small meeting the
good and able men—and perhaps some giants amongst them—
express themselves with much greater ease, with much le
restraint, than they do at any formal scientific congress. In su
a circle as ours today we can afford to say, "I don't know"; w
can afford to say, "My best guess is this or that". And we ca
present an hypothesis without pretending that it is a prove
fact.

Little "Professionalese"

Now I think what has brought about this hope of re
integration within a multi-disciplinary approach was the extr
ordinary lucidity with which matters were presented her
I think it was the first time that I have seen psychiatrist
psychologists, and sociologists really understanding what th
pharmacologists meant. And on the other hand, ps
chologists, the psychiatrists, and the sociologists dispensed wi
what we call in America "professionalese". This lucidity
expressing oneself in human language, in discarding that odio
"professionalese" which very often just hides ignorance is
tremendous importance.

The philosopher Wittgenstein, who used to be called th
Pied Piper of Oxford, wrote a very important little book entitle
"Tractatus Logico-Philosophicus". It is a small book, and th
last sentence of its reads as follows: "Whereof one can spea
one can speak in simple and unmistakable terms. Whereof on
cannot speak, thereof one must be silent." ▲

Addictions

Volume 8, No. 2 Autumn 1961

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COHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (925-8951)

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Addictions

AUTUMN, 1961

EDITOR'S NOTE . . .

Major articles in this issue of ADDICTIONS tend to stress the public health aspect of human conditions dealt with by the Foundation. This has been implicit before, but perhaps the implication has not been made so clear.

Many concerned people look upon alcoholism as a tragic personal and family problem; but its broader impact on, and cost to, the total community may not always be seen. Certainly the total health of the individual—physical, emotional, and spiritual—is affected by the uncontrolled use of, and dependence upon, alcoholic drinks. So too is the total health of the community—including the industrial community—affected by the high and increasing prevalence of alcoholism in this province.

Recent activities of our Education Department in connection with the Ontario Public Health Association and in collaboration with public health nursing groups, both official and voluntary, have revealed a number of ways in which the Foundation's training and consulting functions can be used to greater good effect.

We earnestly hope that the articles by Drs. Glud, Baillie, and Holmes in this issue will be read and well considered by everyone concerned about the public health of Ontario.

The Public Health Nurse as a Member of Alcoholism Treatment Team

*by Eric Glud, M.D.**

THE AIM of this paper is to discuss the possibilities of public health nurses becoming more active in detective and corrective roles, especially in regard to the problem of alcoholism. Our public health nurse force is a reservoir which could aid many more people if a clearer understanding and delineation of how to better use the available resources could be obtained.

Before discussing any details of the practical approach towards the achievement of this goal, it appears essential that we understand and agree on the goal itself. Then will follow some remarks about situations in which the public health nurse meets the alcoholic, how she works with him, and what could be done with additional training for the graduate or undergraduate nurse. Finally, the implications of such training will be mentioned with special emphasis upon the emotional reactions experienced by workers in the field of alcoholism.

Acceptance of Responsibility

It is crucial that the problem of alcoholism becomes an accepted responsibility for all branches of public health nursing. This does not necessarily mean that it become a primary focus, but rather that recognition be given to this serious problem. Acceptance of this responsibility is basic to any rehabilitation work with alcoholics. Nurses and other clinical workers must believe that they can help and "give" despite many rejections. These patients do not easily establish relationships with other people and often do not know the warmth and give and take of human relationship. Because of their distrust of people, work with them is often very frustrating. It is important for public health nursing organizations to establish a policy in regard to working with alcoholism. But, in addition, each individual nurse must decide for herself whether her own feelings allow her to

*Dr Glud is Chief Psychiatric Consultant, Office of the Commissioner on Alcoholism for the Commonwealth of Massachusetts. He presented this paper at a public health nursing conference at Chatham, Mass., in May, 1959.

accept this responsibility. She must be aware of the frustrations in the work and regard it as a challenge.

Where the Public Health Nurse Meets the Alcoholic

If it is agreed that the problem of alcoholism is within the sphere of responsibility of the public health nurse, it is worthwhile to consider under what circumstances the nurse meets this socio-psychiatric problem which pervades society on all levels. The so-called "bums," the unfortunate destitute men on Skid Row, constitute less than 10 per cent of the 5 million or more alcoholics in the United States;* the remainder have more ties with society and reality. They cause less overt trouble. Nevertheless, many families live on the brink of breakdown socially, emotionally, and economically, yet attempt to deny the seriousness of their problem. This is why alcoholism often is a "hidden illness."

Nevertheless, there are numerous situations where a nurse working in the community or hospital may stumble into the problem of alcoholism. She may be concerned with a new-born or premature infant, and incidentally learn of an alcohol problem in the family or she may learn of the problem of alcoholism among patients in a tuberculosis hospital, chronic hospital or general hospital. Until now there may have been a reluctance to tackle these problems. This is in part due to the widespread opinion that it is an impossible job to do any extensive rehabilitation. We think it is possible —perhaps not 100 per cent—but it is possible and worthwhile to offer help. Yet it takes courage to tackle the situation, and it takes specific knowledge.

Specific Knowledge of Resources

Others have dealt with the problems of alcohol and alcoholism in general. Likewise, information about treatment facilities in general mental health agencies as well as in in- and out-patient clinics specializing in the care of alcoholics has been discussed. We shall only stress here the importance of knowing all existing facilities. It is not only the specialized agencies mentioned above that participate in the treatment of alcoholics. The Salvation Army, Alcoholics Anonymous, volunteer organization, and the church also have resources for individuals and for families in need.

Knowledge of existing facilities, professional and volun-

**Latest estimates for Canada place the number of alcoholics here at more than 217,000 at the end of 1959.*

teer is essential, but such knowledge alone does not create teamwork. This must grow gradually and effort is required to coordinate and to effect good liaison. Further, the degree to which teaching about alcohol and alcoholism is included in nursing schools' programs will enhance the ability of the public health nurse to function more effectively with the special problem of alcoholism. For the already trained nurse, post-graduate training in public health agencies or in-service training programs in general hospitals is equally important. This has already been recognized by a number of public health agencies. Additionally, these agencies have established a close liaison with mental health agencies, and are using psychiatric consultation. Successful teamwork between public health nurses, and mental health consultants depends on many factors. One of these is the gathering of adequate case information by the nurse.

Selective Data in Case Histories

Speculations based upon a sketchy case history do not help the nurse in appropriate planning for the approach to a particular family. Therefore, sufficient data must be gathered from the family, employer, friends, and others in order to understand the total family interaction. It is an art to interview and it takes some time and skill to learn it.

Selective data should be obtained so that an understanding of the total family problem can be arrived at. The severity of the patient's emotional disturbance is a relative matter, yet it is imperative to get some assessment of the client's motivation for seeking help, and assess which avenue of approach is open for establishing a relationship with one or more family members. This is more important than finding out whether the client is psychotic, borderline neurotic or psychopathic. Extensive evaluation and assessment of strengths and liabilities are of greater value to the nurse than establishing a specific diagnosis. Therefore, it is important to help this nurse to delineate the treatment situation in terms of defining the problem and indicating in what areas further questioning, support, or other activities are necessary.

In this connection a writer in the field of nursing, Helen A. Sutton, says:

> "What an aid to the mental health of the country if all nurses and their helpers were as well prepared to attend to the emotional needs of patients as they are equipped to care for the physical needs. This means that the nurse should be equipped for what nursing educators call "total care," and this is a big task."[1]

It is extremely important in the management of psychological problems to understand both personality strength and liability, as well as some of the tenuous balances within the family structure. These kinds of psychological concepts can be taught.

eaching of Psychological Concepts

In teaching psychological concepts, G. Bibring feels it is essential to provide the trainee with the understanding that "there is more to a person's emotional processes than appears on the surface and that his behavior patterns and attitudes are the result of conflicts between his deep strivings and his defensive methods against these strivings, developed in a slow adaptive process under the impact of environmental pressures and demands. However fixed these habitual behavior patterns may seem, one may recognize and diagnose the original underlying conflict. These conflicts are revived and intensified in times of stress."[2] Matters such as these can be understood if the trainee is equipped with basic knowledge of personality development and psychological needs and conflicts. Only with such a basis can the adult personality structure, as well as his emotional needs and ways of dealing with stress, be well understood. However, with this knowledge the trainee should be able to investigate and adequately evaluate those human problems they encounter.

This does not mean that in teaching psychology we intend to make psychiatrists out of our nurses or other trainees. Psychotherapy as practiced by a psychiatrist has the objective of aiding the patient towards a more realistic solution of his inner conflicts by helping the patient to gain insight into his patterns of behavior and their connection with childhood nuclear conflicts. In other words, psychotherapy proper deals to a large extent with the patient's psychic reality, and unconscious motivations.[3]

The nurse cannot, in her role, properly investigate unconscious processes. However, she can use her understanding of human behavior to deal with the patient's objective and conscious reality. It is important to understand the patient's dominant personality traits and central needs in order to

[1]Helen A. Sutton, R.N. "Child Guidance and the Nurse," *Child Psychiatry*, edited by Harold A. Greenberg (G. P. Putnam, 1950).
[2]Grete L. Bibring. "Psychiatry and Medical Practice in a General Hospital," *N. E. Journal of Medicine* 254: 366-372 (Feb. 23, 1956).
[3]Malvina Stock, M.D.: Paper given at the regional meeting of the American Association of Psychiatric Clinics for Children, Boston, Mass., 1957.

render support in a positive and appropriate way. This can be done only if the nurse has some understanding of how unconscious factors affect human behavior, and some knowledge of how personality structure gradually develops. In dealing with alcoholics it is important to understand the dynamics of addictive or symptomatic drinking and to accept the fact that these people suffer. No one can help alcoholics if consciously or unconsciously he discriminates against them. Detrimental to any helping situation that one attempts to create, are negative attitudes towards drunkenness, excessive drinking, or dependent immature personalities.

That Magical Power

A male alcoholic may be dominated by hostility, acting impulsively and unable to tolerate any frustrating situation. He may believe in his own magical power which he so often expresses when he says, "I can stop drinking when I want to." His dependent needs and wishes are far beyond the legimate needs of an adult. Nurses, as the helping agent in a family, often will be threatened by these dependency needs because the patient will try to force the nurse into a situation where the patient unconsciously wishes either to be pampered or to be rejected. He reacts to his environment not as a grown-up but as a child. Therefore, the nurse must learn not to fall into the role of either over-identifying or over-sympathizing with the patient and his problem. Rather, the nurse should attempt to survey the situation and strengthen the existing well-functioning parts of the patient's personality as well as those constructive assets which may be found in the total family situation.

An illustration of this concerns a bright but very infantile white-collar worker who suffered from intense feelings of inferiority. He attempted to compensate for these through arguments with fellow workers and bursts of rage at home whenever he felt his position of power was threatened. Another destructive attempt at compensation was drinking and withdrawal from the family to a neighborhood bar, where he, by handing out the drinks, became the admired center of attention. The results are obvious. Both his work and family deteriorated. When he came to the attention of a clinic, it soon became evident through the history that one avenue of constructive compensation for this man was the possibility of reviving in him some interest

in youth work and union work, an interest which he and his wife shared earlier. Community friends were mobilized by the clinic and they succeeded in reviving the interest by turning over some special projects to our patient.

Through these activities he compensated in a healthy way for his feelings of inferiority and, without our delving into his unconscious, was able to abandon the bottle and become an asset to his family and society rather than a liability.

As you can see from this illustration, an understanding of the essential dynamics of a typical alcoholic person is very valuable, and I will briefly elaborate on this matter.

haracter Structures Frequently Found

There have been many discussions as to whether or not there is a so-called "alcoholic personality." I do not believe such exists, but within the framework of psychoanalytic thinking, we have been able to delineate character structures frequently found among these people who choose alcohol to relieve their tensions. As with any emotional difficulty, there is not a single "type" but a variety of people who come to suffer. Even with the problem of addiction the drinking pattern may take different courses. Some people can drink during weekends for years, still maintain their family ties and tenuously hold the family together. At the other end of the spectrum, a man may go through a brief period of marriage and drinking in his early twenties and drift rather quickly towards becoming what we call a skid-row alcoholic, without any ties in life except for the "nurturing" bartender and "protecting" police or correctional officer who provide shelter, and a certain kind of stability.[4]

The ability of some of these patients to relate to other people appears to be seriously impaired or undeveloped. Despite this we find some alcoholic patients very charming; however, this charm is frequently superficial. The charm is used "to get" from other people, while their ability to "give" is rather impaired. Mature people have learned the give and take of life and know that in order to get, one must give. Essentially, however, alcoholics want so much that nobody can fulfill their wishes. This is like a child who wants all his wishes fulfilled instantly and otherwise throws a temper tantrum. That is acceptable during the first year of life, but

[4]David Myerson, M.D. "The Study and Treatment of Alcoholism," *N.E. Journal of Medicine* 257: 820-825 (Oct. 24, 1957).

not thereafter. Everyone has to learn that one cannot get total attention. We all have to learn to accept our needs even though they are not totally gratified. Some alcoholics, it seems, never have learned this. They expect total attentiveness and, when it is not forthcoming, feel that they are disliked.

For such a person there is almost always an "all or none" law. If he can't get everything from his environment, he will attempt various substitute solutions. At first he may throw a temper tantrum and get raging mad at home. Unsatisfied, he usually walks out and tries to appease his inner needs through drinking and the special group-supporting admiration which the bar provides. Without it he feels unconsciously that everything is lost and he is not worth anything. This is irrational thinking to us, but for the alcoholic it has become his inner psychic truth. This sort of mechanism is his worst enemy, because it allows him to believe that his family and the world around him are against him. He accepts this distortion of reality, i.e., his "projections" are truths to him. No amount of persuasion with a patient like this will succeed in bringing him to accept our point of view.

Rehabilitative Efforts

We find that only through the continued presence of kind and helpful friends, as well as a constant relationship with a member of a therapeutic team, may the alcoholic gradually accept our reality instead of his own unreal world. This acceptance of his world for a long time, is what makes psychotherapy and management of alcoholics an exceedingly difficult matter. The nurse and the psychotherapist must be prepared to deal with their own frustrations as well as those of the patient, while they are exploring all reality avenues in dealing with the patient. Many professionals unfortunately give up too early when faced with a difficult situation, and blame themselves falsely because of their believed failure.

The alcoholic often deeply resents having less attention paid to him than to other members of the family when the nurse is visiting. He may feel displaced when a new child arrives, and jealousy and attention-demanding is evident in numerous ways. He also may like to start arguments with everyone and believes that "nobody can fool him." He knows better than everybody else, *i.e.,* his world of thinking is right, everybody else is wrong.

Another practical point to remember is that if one asks a patient to take any medication or seek treatment the request may be refused. He is not weak, powerless or sick, the alcoholic argues. This massive denial is used to defend against inner unconscious anxiety. This is generated by the fantasy that the patient feels he really is "empty and a nothing." Such ideas cannot be allowed into consciousness. To overcome it one must repeatedly, over a period of time, support the alcoholic and show him how much it means to everybody around him that he gets well and how important it is for his well-being that he be given all the special care possible from the appropriate facility. His unrecognized fears of being abandoned or deserted must gradually be allayed in order to achieve any success in reaching him.

sy to Lose Patience

These patients' quarreling and repeated benders are exceedingly difficult to deal with. It is very easy to lose patience with them and react to the patients' critical and aggressive behavior with anger and counterattacks. This is especially contra-indicated. The alcoholic often looks for such arguments in order to continue to blame his surroundings, rather than looking at his own behavior.

In such situations we must listen calmly to the patient and state firmly and kindly that we wish to be helpful and friendly; that he will ultimately have to make the decision as to whether or not he can or will accept our viewpoint and thereby our help. When the patient hits "rock bottom" and does seek help, it may be said that the small core of healthiness in the patient's personality has taken command and allied itself against the otherwise overwhelmingly sick part. The nurse or any other person who attempts to help the alcoholic, therefore, must not participate or become a partner with this sick part which contains the patient's hostilities. One must be neutral, not take the hostility at face value, but try to work with the anxiety which generates it.

Another conflictual matter in this internal struggle is the poor self-image our alcoholic patients often have. Because of it they attempt through "powerful expressions" to counteract their own unconscious fears. Building up self-esteem as previously illustrated through utilization of groups, hobbies, etc. is a constructive aid to their self-esteem in contrast to the destructive pseudo-esteem created by alcohol.

Drinking is a pleasurable matter, except for the five

million or so Americans who have trouble with drinking. Therefore, to educate about alcohol is a difficult matter, since it suggests that somebody might want to interfere with something that is acceptable to most of us. Many people, even among our professional group, are rather biased about the problems related to alcohol and alcoholism. They may take a rather rigid and strict moralistic viewpoint when it comes to dealing with the alcoholic patient and his family. The nurse must first settle these matters with herself in order to have a positive attitude. Otherwise, she cannot successfully participate in the therapeutic community with which we need to surround our alcoholic patients. With a thorough knowledge of psychological concepts and of community facilities, the public health nurse can play an important part in the rehabilitation of the alcoholic. ▲

Medical Profession Seen as Leader in Combatting Narcotics Addiction

*by S. J. Holmes, M.D.**

LET me preface my remarks by asking a question which has long troubled me—namely: "Why do we of the medical profession continue to allow the narcotics addict to be treated as a criminal?" It seems to me that this general attitude may be based on several possibilities:

1. We are in agreement with this attitude and regard the addict as a social nuisance who should be punished.

2. The addict makes us feel insecure because of our general ignorance with regard to his total problem which he presents to us in a non-trusting, aggressive, challenging way.

3. We do not want to become involved with the present legal technicalities associated with such cases in which the implications are not too clear. (The law looks after the problem of this minority group by incarceration for charge of possession or allied crimes.)

4. The possibility of associated guilt on our part perhaps related to the high incidence of self-medication of one sort or another, including alcohol, which we are not individually prepared to face and which is perhaps manifested in our tendency to overprotect those of our profession who may be so involved.

What I have to say on the treatment of narcotics addiction derives from thought, experience and reading which have been stimulated by my contact with the Drug Addiction Clinic at the Mimico Reformatory since its opening in 1956. During this period we have seen over 200 addicts in a fairly limited approach to the overall concept of treatment and rehabilitation.

It seems to me, that narcotics addiction as differentiated from narcotics trafficking is a public health problem and we

**Dr. Holmes is a psychiatrist who has been for several years associated with the treatment of addictions at the Alcoholism & Drug Addiction Research Foundation of Ontario and at the Drug Addiction Clinic at the Mimico Reformatory. He presented this material in a panel discussion on narcotics addiction before the Section of Psychiatry, Academy of Medicine, Toronto. It was originally published in the September 1961 Bulletin of the Academy.*

of the medical profession must take a more active interest and give more leadership in its management than we have heretofore. In order to do this we must become more aware of the problem and its ramifications from more co-ordinated research into the legal, social, physiological and psychological aspects based on a premise that the narcotics addict is a sick man rather than a criminal. This procedure would assure that the narcotics addict would be treated in a manner similar to any other citizen with a medical problem. However, if the addict commits a criminal act, the law should deal with him as it would with any member of the community.

Whereas, it is not a crime to be a drug addict in Ontario, it is a crime to be in possession of narcotics illegally. Thus, the course of addiction varies with the laws of the country as well as the economic status of the addict. In England, it has been reported that there is little association of criminality with addiction, since the British control system looks upon drug addiction as a medical problem and keeps it primarily in the hands of the physician. The decision whether to give regular prescriptions to the English user is left to the doctor, usually after consultation with another medical man. He does not have to report addicts under his care but records must be kept both by him and by the druggists who fill the prescriptions. The British system applies pressure on the doctor to persuade the addict to accept treatment for cure of his addiction but allows doctors to prescribe sustaining doses of narcotics for habitual users. As a result under the drug act addicts can obtain narcotics by prescription for 14 cents which takes away practically all incentive to secure drugs from illegal sources.

Medical and Professional Addicts

Under our system those addicts who are categorized as medical may continue to receive drugs from their physicians not ostensibly for their addiction but for their physical disease. The professional person who is addicted may get drugs through legal sanction provided by professional status. Thus, both of these groups are able to retain their economic and social status working and living within the acceptance of their neighbors.

The larger majority of addicts in this country are, however, forced into social deterioration because of the exorbitant

cost of drugs. Heroin sells on the black market at $6.00 per capsule and the addict uses about four to six capsules per day on an average. To obtain this money narcotics addicts must rob, steal, prostitute, pimp or peddle drugs. Thus the addict's tremendous craving for drugs and their great cost are his most pressing reason for committing crime.

Although we commonly speak of drug addiction as a disease, it is more properly a symptom of disease rooted in social and economic conditions which tend to create dissatisfaction, unhappiness, conflict, tension and strife in the minds and souls of human beings. When the fundamental emotional stability and equilibrium of the individual are not equal to these emotional stresses some persons consciously or unconsciously seek the psychological or chemical means which may be available for a measure of relief even though that relief is overshadowed by involvement in greater conflicts and tensions which may be of a permanent nature.

stimated 1,000 in Ontario

The problem of drug addiction is world-wide but it differs somewhat from one part of the world and from one country to another. Accurate statistics are impossible to obtain but it is estimated that there are over 1,000 addicts in Ontario who are divided into professional, medical and criminal addicts. The latter group, using heroin, by far outnumber addicts using all other forms of narcotics. There is some evidence that the numbers in this group are growing—especially in the younger age groups. Three large centres account for most of our addicts—with Greater Toronto having the majority and Hamilton and Windsor following in that order.

Many problems have been treated by the legal, moral, punitive approach. This has not solved the problem and finally the medical approach has been tried with much better results. It has now become universally accepted that alcoholism is a medical and psychiatric problem even though it is linked to more criminal and social problems than all the narcotics drugs put together, and we are beginning to see that the medical approach is the best way of dealing with this problem. When we come to drug addiction we have been trying the mainly punitive approach, we have increased penalties, we have hounded the drug addict and we have brought out the idea that any person who takes drugs is a

most dangerous criminal and a menace to society. We have perpetrated the myth that addiction to opiates is the great cause of crimes of violence and of sex crimes—which is possibly a holdover from the days when the use of cocaine was more popular. It is a fact that the punitive approach does not deter the non-addict dealer or the addict. Jail confinement also inducts new addicts into the underworld. The young addict learns from other prisoners what amounts to a complete course in drug addiction and how not to work at all. The punitive approach also ignores research and education and therefore does nothing to decrease drug addiction.

Prevention Through Better Family Life

From the point of view of prevention we must develop a sound approach to the problem of juvenile delinquency of which drug addiction is only a facet along with alcoholism, criminal and other anti-social behavior. In the light of our present knowledge, the commonest and most disastrous conditions leading to delinquency are those centred about the family life. In this the potential delinquent is one who at some stage of his development has been blocked in his needs for a satisfying relationship in the family. Unfortunately, emphasis is still placed on protecting society—not in understanding the individual. Little progress can be expected in the prevention of delinquency or drug addiction until family life is strengthened, not only in relationship to living conditions but also by breaking into the vicious circle of character damaging influence on children exerted by parents who are themselves the distorted personality products of adverse parental influences through intensive instruction of each generation of prospective parents in the elements of mental hygiene and the requisites of happy, healthy family life. To my mind the beginnings of this should be regarded as equally important to reading, writing and arithmetic as all too long we have been concentrating our money and energy in dealing with the finished product of such social circumstances.

There would appear to be a pressing need for the co-ordination of the knowledge and skills of interested physicians and professional nurses, social and welfare workers, lawyers, judges and law enforcement officials, to deal with those who are ill from this disease, and this type of approach would necessitate some changes in the Opium and Narcotic Drug Act to prevent spread of this contagion.

From this latter concept, we must consider the addict not only as a sick person but also a potential source of infection to others as it is in his interest to introduce others to the drug as it makes him less of a social outcast, it makes him feel less guilty and it makes it easier for him to obtain the drug and perhaps at a lower price.

·ofessional Leadership Is Needed

The total approach to the problem of narcotics addiction relating to both its prevention and treatment within or without penal institutions should be the responsibility of an expert committee of interested people from the aforementioned professional groups and in this regard medical people, should be, in the tradition of their profession, eager and willing to lend leadership and assistance.

I have a few thoughts from my own experience which I would pass on to such a committee for their consideration in such a program:

1. The addict charged with criminal offence related to the support of his addiction should be given a short definite sentence preferably served in a situation organized for clinical treatment with a longer indeterminate sentence for follow-up purposes for those addicts who indicate a willingness to become involved in treatment and rehabilitation.

2. The addict charged with possession should not be tried and sentenced merely but should be referred to treatment facilities.

3. There should be no let-up in the pursuit and punishment of those who are not addicted and who are associated with drug trafficking. In the case of the addict who is charged with possession and trafficking and who at that time is addicted, special consideration with regard to sentence and referral to treatment should be made.

ss Negative Approach Will Help

In addition to this from a general point of view we come to a consideration of the treatment of the individual. In this approach the attitudes of both the patient and the members of the treatment team play a most important role. At the present time, from my own observations and the reports of addicts it would seem that our hospitals and doctors in general take a pretty negative, pessimistic attitude

toward the addict—much in keeping with the law makers and law enforcement agencies. The fact that the attitude of many addicts may be pretty negative toward a life without drugs and the relapse rate is very high should be expected and accepted rather than looked upon with disdain or criticism of the patient. We cannot realistically ask that the addict never use drugs again but we can ask and expect him to go to work and in this way build a new pattern of living. Most addicts are quite ambivalent in their desires with regard to drugs. They have a desire to stop using which we can strengthen by acceptance and understanding at all times whether initially or during relapse and in this way put the onus for his behavior on him. Present attitudes of rejection, punishment, making him kick his habit all help to expiate his guilt feelings and make relapse more acceptable to him as well as return to the acceptance he finds in his sub-culture of drug addicts. In further research in these areas it may become apparent that our methods need more improvement and a positive outlook in this will allow for progress to be made by the open mind.

Patient's Motivation Is Critical

The attitude of the patient is of prime importance from the point of view of what can be effected. Even in our present varied treatment possibilities the fact that some addicts make satisfactory recovery is perhaps more an attestation to their sincere motivation than to the efficiency of our treatment situation.

The addiction clinic at Mimico has been set up primarily as a pilot project for an approach to treatment and research of addicts under sentence who volunteered for such treatment as a means of bringing together addicts from various institutions who have passed a classification or screening board whose assessment is based on a reasonable expectation of co-operation in such a unit. Up to January 1960 there have been approximately 200 addicts pass through the clinic and a review of these cases in June 1960 revealed about 10 per cent remission with the longest being three years and the shortest in this group a matter of six months. From the point of view of the approach to the individual we could discuss at considerable length the thinking of others rather than personal experience with regard to the advantages and disadvantages of home withdrawal, office or outpatient with-

drawal or hospital withdrawal but time does not permit and here again medical control and research may one day settle the factors in such arguments. However, a general plan of treatment can be set out in several phases:

Management of Withdrawal

I have only a few remarks to make with regard to withdrawal. I believe everyone, regardless of his position should be offered a humane withdrawal from his drug and the best place for this is in a controlled setting in a hospital. The fact that at this time the addict who has undergone withdrawal previously, will have high anxiety, will falsify his dose, will conceal drugs on him or in him, will try to bribe or otherwise involve relatives, friends and attendants to supply drugs —should be considered normal behavior for an addict about to undergo or undergoing withdrawal. During this phase it varies one from the other the degree of symptoms manifested from both organic and psychological factors and some workers have suggested that this is a very vital period in building up rapport with the addict as well as getting him to see the relationship to pain of living and his use of drug for relief to reinforce his motivation. From a chemical point of view the usual practise has been to use morphine or methadone as substitute therapy. The usual dose is to start with morphine gr. ¼-½ q.i.d. and after stabilizing on morphine to substitute methadone in proportion of 10 mg. methadone for 30 mg. or ½ gr. morphine or 15 mg. or ¼ gr. heroin. The dosage is gradually reduced over a period of seven to 10 days. Supportive therapy with atropine, bismuth, barbiturates, intravenous feedings, etc., may be necessary on clinical evidence. The use of Chlorpromazine for withdrawal has been advocated in doses of 50 mg. I.V. to 100 mg. intramuscularly following the abrupt withdrawal after stabilization on morphine. The doses are given at four hour intervals and it has been found that the patients sleep for as long as 12 hours intervals and are fed intravenously. After two or three days the dosage is reduced and given orally with reports that patients are co-operative and without undue anxiety. Some addicts that I have talked to who have had such therapy do not endorse it so wholeheartedly but recall a period of being inert on the bed suffering withdrawal but unable to get up and around and "kick" their habit which in reality to them is another form of punishment. Prior to withdrawal any

existing severe medical condition such as heart failure, uncontrolled diabetes, severe infections or other surgical emergencies should be treated while the narcotic dose is kept at a comfortable level.

At the present time in our group of patients the withdrawal has been done at the jail level to varying degrees of the desired optimum and the patient has served the first part of his sentence so that he comes to the clinic for the first phase of his rehabilitation in the last three months period of his definite sentence. During this period the stress is on physical therapy with supporting drug therapy when indicated, adequate diet, exercise, recreation, occupational therapy, rest and work. Lectures, mental health films, group discussions and individual psychotherapy of supportive or uncovering nature are aimed at a reorientation toward normal living.

Rehabilitation beyond the Hospital

This post discharge rehabilitation period is perhaps the most important if not the most crucial period and it is here that our present resources are sadly lacking. Our present experience would indicate a need for some legal control such as parole or probationary periods up to two years and possibly four with some addicts. Associated with the need for outside assistance through job placement, social agencies, religious groups, A.A., N.A., and mental health clinics is a need for public acceptance through education. Possibly more ideally, the organization is indicated of a central clinic for both in-patient and out-patient treatment, for continued treatment of the personal and allied factors associated with the addict's rehabilitation as well as facilities for the treatment of relapses when indicated, and to which the addict could relate as a half-way house and from which other related clinical, social or community referrals could be originated. Such a co-ordinated centre could be the focus around which further education and research could originate as it is primarily by these means that the total illness can be more realistically approached.

I have no doubt that when the medical profession is properly aroused and accepts its responsibility toward this group of sick people it will proceed with the leadership and progress that it has made in the past with what have formerly been considered curses of humanity such as venereal disease, mental illness and alcoholism. ▲

A Report to the Martian Academy on Earth's Curious Drinking Cult

*by R.Z.**

FELLOW members of the Martian Academy:

My report on the first Mars expedition to planet Earth would not be complete without brief mention of the curious custom which centers around a substance which Earth-people call alcohol. Although alcohol is unknown here on Mars (our planet life and atmosphere do not contain the necessary elements to manufacture it), it is consumed in many forms on Earth.

Alcohol is a colorless, volatile liquid. Since it causes a burning sensation on the tongue and in the throat when imbibed, Earth-people combine it with water and flavoring agents to make it potable. Also, it is often given a pleasing amber color, for aesthetic effect.

The ritual of alcohol-drinking is most difficult for a Martian to comprehend. We have nothing like it on our well-ordered planet. Earth-people of both sexes drink alcohol with intense fervor, gathering for the ceremony in dimly lit temples where they must raise their voices to be heard over the sounds from automatic music machines.

The Cult's Grand Mogul

The alcohol is dispensed by a Grand Mogul whose robe of authority consists of a white cloth tied about the waist and hanging freely to the knees. In larger halls he is assisted by hand-maidens who wear similar white aprons.

The Mogul officiates at a mahogany altar backed with colored lights, ornaments and rows of glass containers of varying shapes, but all filled with the solution which he dispenses. An alcoholic potion is prepared in small glasses by the Mogul and handed to the slavish subjects over the barricade. This evidently symbolizes his exclusive and elevated role.

In exchange for his quantity of alcohol, the drinker hands the Mogul one of the tokens of metal or paper which are prized so highly by Earth-people. The large number of these tokens

**R.Z. is a member of Alcoholics Anonymous in Council Bluffs, Iowa, and this unearthly bit of whimsy appeared originally in the May 17, 1961 issue of the A.A. GRAPEVINE.*

which Earth-people exchange for drinks of alcohol is evidence of the importance which the drinking ritual plays in their lives.

One member of the MEF (Martian Expeditionary Force) sampled some of the alcohol and reported decidedly unpleasant effects: dizziness, difficulty in speech articulation, cloudy memory, a lethargy in the limbs.

The Earth-men who were acting as our hosts insisted that the volunteer try additional samples. There were remarks about a bird (a type of Earth-creature) flying on one wing. Our volunteer protested, but not wanting to be impolite, he allowed additional doses to be administered. What followed is outside the scope of this report; in brief, our poor companion had to be carried back to our spaceship to recover. He reported, upon regaining consciousness, that the experience was somewhat like the illness we often endure on Mars during the annual advance of the ice cap, when we have to resort to artificial foods.

The Search for Happiness

We concluded that alcohol-drinking is bound up in some way with the search for Truth and Happiness which is such an obsession with Earth-people. Some alcohol-drinkers are more devout and persevering in this search than others, and their ecstasy often reaches a trance-like state, at which time they fall to the ground unconscious. Others make their way forth from the hall, uttering incoherent prayers and propelling themselves erratically in machines known as automobiles.

The alcohol persuasion leads a few to a monastic way of life. They renounce family and friends, their vocation and all worldly pleasures, to carry out their devotionals. Some of these retire from human company for days at a time, to perform secret rites which, we are told, alternate between lengthy trances and disordered wakefulness.

A word must be said about a small but growing sect of comparatively recent origin, made up of those who have attained the rank of High Prophets of the alcohol cult. They evidently have found the answers which others are seeking in drinking alcohol. The knowledge was gained through such suffering and hardship that it is coveted and passed on only to those whose similar experience has led them to the threshold of understanding. These chosen ones meet surreptitiously, refer to each other by first names only, and their membership in the sect is known only to other members.

While each of them was at one time a dedicated practitioner

of the alcohol-drinking ritual, they now joyfully shun alcohol on all occasions and devote much time to instructing novices in the secrets of the order.

Serenity Betrays Anonymity

They speak frequently of their search for Truth and Happiness but under their new doctrine these treasures are found everywhere *except* in alcohol. This radical belief is regarded as subversive by many Earth-people, so members of the sect go about in anonymity. Their anonymity is not perfect; we noted they wore expressions of serenity seldom observed on the faces of other Earth-people, and they seemed to retain admirable composure at times when others were wringing their hands over the vexing problems of Earth-life.

It is our recommendation that the Martian Academy undertake further study of the alcohol cult on Earth to learn to what extent it may be responsible for the chaotic social conditions on that unfortunate planet. When our next expedition is dispatched —carrying colonists and missionaries to teach the Martian Way of Life—we must be equipped with as much knowledge as possible to help us get along peacefully with the Earth-people. If, indeed, it is possible to get along peacefully at all with people of such peculiar habits. ▲

Stated Policy, Genuine Interest, and Follow-up Vital To Company Program

*by J. H. Baillie, M.D.**

THERE is little doubt in the minds of most health authorities that alcoholism is a major public health problem. Some place it as the most important problem in our community today, others rank it after cancer and heart disease. I am not too concerned where it is placed in relative values other than to realize that we must accept the fact that this is a widespread disease and appears to be increasing in importance. The estimates as to the extent of the disease vary anywhere from half of one per-

**Dr. Baillie, who is Regional Medical Director for the Western Region, Bell Telephone Company of Canada, presented this material to the Ontario-Quebec Industrial Medical Conference in October, 1960.*

cent to six percent of the community. No matter what figures you pick within this range, we are dealing with a serious problem. In industry, in Canada, it has been estimated that the cost of alcoholism is in excess of $100,000,000 a year and again I do not know how accurate such a figure is. However, when you realize that the majority of patients come from the age group between 35 and 55 (our peak production years) and that most alcoholics or problem drinkers have considerable absence in excess of the average and that usually, even though on the job, production is limited by the extent of the hangover or intoxication; it is not hard to understand how one arrives at such astronomical figures. It would appear that no matter how we look at this illness, it is a problem to industry as well as the community generally. There is no simple solution and in fact I know of no real solution.

Working At It Since 1951

Because of the obvious wastage of manpower and the failure of the so-called disciplinary approach to the problem, our company decided in 1950, after the then medical director had successfully rehabilitated a well known case, to change their approach from that of discipline to treatment of an illness. When this decision was made by top management in early 1951, a policy statement was issued to all management personnel, which at that time was approximately 4,500 people. The problem drinker, or alcoholic, was defined as an ill person and as such was to be dealt with in the same manner as other illnesses, entitled to sickness benefits or disability pension, and encouraged to seek medical or other help without delay and the disciplinary action, which is sometimes required, was to be delayed until the health factors had been adequately reviewed and treatment undertaken without success. Now, as most of you know, it is one thing to write a policy and another thing to get its acceptance down through the lines of organization. In order to get an understanding of this policy to as many people as possible, the medical department undertook to attend management meetings at which this topic was discussed. We started these meetings 10 years ago and we are still at it. Other means used to explain the policy to the management people and through them to the employees were: the use of articles in the Bell Telephone official journal, news bulletins, and the use of case discussion techniques both in management groups and on an individual basis. Both the physician and nursing staff of the medical department take

part in this educational effort. In spite of the rather widespread dissemination of this policy material, many management people, assuming that the problem did not exist in their groups, paid little attention to what was being said until such time as they became involved with a case in their own group. If at that time we were successful, with the assistance of A.A. or outside treatment agencies, in effecting rehabilitation of a disabled employee, then the management concerned with that particular employee became enthusiastic supporters of the program and referrals from that particular district increased. In other words, the success of the whole program depends to such a large extent upon management's understanding and their ability in case finding and referral, that it behooves any medical group who advocate a program regarding alcoholism, to see to it that management are provided with the information necessary for them to carry out their part of the job.

Three Routes Into Treatment

Problem drinkers or cases of alcoholism are seen in our medical department by one of three means — they come in on their own looking for help, they are referred by management, or they are identified by the medical department staff during some other type of visit to the department: for example—on a periodic medical examination or return-to-duty exam. When the diagnosis has been made, or even if we are sufficiently suspicious to consider the diagnosis, we embark upon an educational campaign with the employee telling him about the disease, what treatment is available, and offering help, referring, if necessary, to A.A. or to one of the treatment centres available in the community. The employee is then seen at regular intervals for a varying period of time, the variation depending upon his acceptance of his problem and his willingness to co-operate.

You might be interested in the results of a recent look we had at our patients in the Western Region of our company. Most of these patients have been seen in Toronto and most of them came from the Toronto group. They are not representative of the extent of the disease in our company, for we, as in most medical departments, have no real knowledge of the frequency or severity of this particular ailment within our employee body. The employees we have surveyed were those where a diagnosis was made and an effort was made to treat the disease. We know of many others who have never been exposed to treatment and we assume there are many others who are receiving treatment

outside the medical department of which we have no knowledge. In my particular group, 85 percent were men and 15 percent women. Their age distributions were as follows: 11 percent were under 30 years of age; 29 percent were between 30 and 40 years of age; 29 percent were between 40 and 50 years of age; 31 percent were over 50 years of age. They came from all departments and both management and non-management people were affected. Fifty-seven percent were referred to us by management, 15 percent were picked up in the medical department on return to duty examinations, periodics, etc., and 28 percent came to us looking for help on their own. We have tried to assess their success with the program of treatment they were exposed to and find that 9 percent of them didn't respond at all, 10 percent made some effort and then reverted, 15 percent have had some change for the better, 28 percent have made significant improvement and may be in a higher classification later, as we use abstinence and time as the criteria of success, 23 percent have reached a 3 star rating and 15 percent have a 4 star or controlled for more than two year record. In other words, 65 percent have shown, or are showing, significant improvement. It is interesting to note that the self-referred have done a little better than those referred by management or picked up in the medical but the numbers are too small to be significant.

I suppose the first thing that confronts us when someone is referred is the problem of diagnosis—what are we looking for? Usually we can quote a text for the classical picture of a disease syndrome. In alcoholism, if we wait until we have a classical picture, we won't need to make the diagnosis — the supervisor will do it for us. If a drinking pattern is causing a problem on the job, that employee has a problem with alcohol —if it causes a problem at home, they have a problem and if it causes a problem with their health, they have a problem. A person who has a problem with alcohol is a problem drinker—this, in my book, is the same condition as alcoholism.

They Usually Deny It

With rare exception the employee denies that he is an alcoholic—quote "I may have a problem with alcohol, but I am certainly not an alcoholic"—unquote. This is not hard to understand—the term "alcoholic" in our culture calls up a picture of a Skid Row character—out of work—patch in pants—three days' beard and a great thirst for coffee—which he incidently needs a dime for! W.H.O. describes alcoholics as—

"Those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily or mental health, their interpersonal relations and their smooth economic functioning". There are several words in this definition which are key words—first—"dependence"—I'm not sure what this means—daily dependence?—what about the man who is a bout drinker—he has long periods of independence!—"excessive drinker"—what is excess to one is a night cap to another. One can pull apart most definitions which attempt to describe an alcoholic because of the diverse nature of the disease and the different ways it affects people and I only criticize this definition to point out the difficulty of defining such a condition. However, we have been and we will continue to be asked to determine if so-and-so is an alcoholic.

Criteria May Be Lenient

I have a feeling that most of us who drink socially have a tendency to be lenient in our diagnostic criteria and to accept too readily the patient's explanation of the extent of his drinking habits. I have found that even though the patient has come looking for help himself, that his habits of rationalization and covering up are so well developed that he can rarely tell a truthful or factual story on the first visit. In order to let the patient find out something about my attitude towards alcoholism, I usually start out by telling him a brief summary of what we know of alcohol. its use and abuse and the disease alcoholism. During this talk I try to establish clearly (a) the difference between social drinking and alcoholism (b) the fact that alcoholism is a disease syndrome (c) that I am interested in the disease not the moral implications (d) that the medical department is willing to help an employee with this problem. If he is still awake, he is encouraged to talk about his own problem and relate it to some of the points I have discussed with him. In those cases where the patient is sent by management with a questionable diagnosis, I reverse the procedure and let him tell me his drinking habits to see if we can establish whether this pattern interferes with the job, his health or his interpersonal relations (especially his family) and then I tell him about the disease *whether or not* I have reached a clear diagnosis—in other words, I have decided that anyone who gets to see us because of a real or implied problem should hear our story even though they deny a problem. Using this approach I have obtained agreement re a problem from several patients who started the interview with "no problem at all".

Here I think I should comment on one of the cliches that we hear all too frequently and which for my money is an excuse, not a fact. It is stated that a patient "only does well when he wants help" and consequently we may tend to not exert the same effort when they appear reluctant. If you remember our figures, you will recall that the results bear little relationship to the referral method. In the long run, and this is confirmed by many investigations, results are just as good with initially reluctant patients as with those who refer themselves. One interesting clinic report from Denmark tells of results from the patients referred by court action being similar to those of the patients who came in on their own off the street. So we should not confine our offer of help or our follow-up efforts to those who seem eager for help—it's more pleasant working with the latter—but all the practice of medicine isn't pleasant.

Encourage Patient's Decision

When we have decided that something should be done about the problem, the patient is encouraged to make the decision as to what he should do. I explain the benefits of A.A., the procedures in various clinics, our follow-up, etc., and depending upon his decision, the follow-up visits are arranged—regardless of the decision, I try to see them again within two weeks.

In the time that I have been associated with this work, I have heard different specialists state categorically that alcoholism is (a) a disturbance of body chemistry (b) a physiological disease (c) a purely psychiatric problem (d) a nervous disease. All of these specialists have had success in dealing with their patients. I don't know what causes the disease nor do I know a sure-fire cure. I can only conclude from the many approaches I have seen, that a common factor exists and that this common denominator is interest. A real interest shown by the physician in his patient was common in all the programs where a fairly high percent of success was claimed. The other point in common was the type of follow-up established—all successful approaches had a system of regular interviews or contacts for a prolonged period in order to maintain the interest.

Interest and Time Required

My point is that a physician should not shy away from the treatment of patients suffering from this ailment because he has not had enough experience or training in this field. The only reason for not undertaking treatment is that he has not or can-

not appear to show a genuine interest in the alcoholic as a patient or he does not have the time required to show the interest.

An industrial physician who does not have the time to treat the patient in the industrial setting should not use this as an excuse for not having a program in the industry with which he is associated. As long as he can make the diagnosis, he can refer for treatment to one of the clinics or specialists treating the illness or he can at least foster a good relationship with A.A. and do nothing further than to initiate some form of follow-up. The interest shown by the treating service and the interest of the industrial follow-up have worked in several large industries where the industrial physician felt that all cases should be referred outside for treatment. I used to think that these industrial physicians were wrong and that there was something special about treating in the industrial setting. Now I am convinced that it doesn't matter so much "where" but "how" they are treated.

I feel that the industrial physician can make one of his best contributions to the employee health picture and win more management support for his program generally by his efforts in this field than in most other parts of an industrial practice. This effort provides management with staff advice on a problem which has bothered them for years. Dealing with the patients, setting up a policy, explaining it, etc., take considerable effort and time, but we have found that it is a most satisfying effort when you see the tremendous improvements in the patient's wellbeing, his family life and his job.

May I close by stating that our approach, a stated policy, a genuine interest, and a good follow-up program has worked very successfully in our company and I think it will work in other industrial settings. ▲

atest Alcoholism Estimates

- *Figures complete to the end of 1959 show at least 217,000 alcoholics in Canada—a rate of 2,100 per 100,000 adult population. (This is up from a total of 208,000 alcoholics the previous year, and a rate of slightly over 2,000 per 100,000 adults.)*
- *Regionally, Ontario's rate is highest (roughly 2,400 per 100,000 adults), followed by Quebec (about 2,300), B.C. (approximately 2,100), the Prairies (about 1,500), and the Atlantic Provinces (roughly 1,200 per 100,000 adults).*

FOUNDATION NEWS . . .

- Six research grants, totalling more than $35,000, were approved by the Alcoholism and Drug Addiction Research Foundation at their October meeting, upon recommendation of the Medical Advisory Board. These cover projects at the University of Toronto and Queen's University involving the following studies: "Changes in the Intrahepatic Circulation Produced by Alcohol", "The Effect of Alcohol on the Metabolism of Nervous Tissue", "A Study of Drinking Behavior Among Ontario Reserve Indians", "Re-Survey of Alcoholism in an Ontario County", and "The Effect of Alcohol on Nerve Conduction".

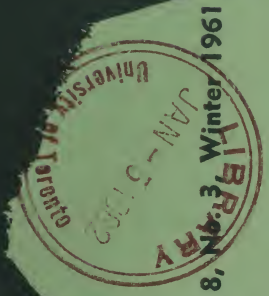
- **H. David Archibald,** executive director of the Foundation, has been elected a member of the executive committee and of the administrative committee of the **International Bureau Against Alcoholism.** This organization began at Stockholm in 1907 and now has its headquarters at Lausanne in Switzerland. It is financed by grants from a number of national governments and its purpose is to foster international cooperation among those who are working toward the prevention and treatment of alcoholisms in various parts of the world.

- **Gordon M. Patrick,** for the past three and a half years executive secretary of the Hamilton Branch of the Foundation, has been appointed assistant director of education at head office in Toronto.

- **Four Canadian members** (H. David Archibald, Dr. E. M. Jellinek, Dr. J. H. Quastel, and John R. Seeley) recently returned from a meeting of the **Cooperative Commission on the Study of Alcoholism** at Stanford University, Palo Alto, California. This was a planning meeting on the five-year program to investigate and correlate all aspects of scientific work aimed at reducing alcoholism.

- **The Fall workshop program** of the Education Department is under way with two groups on a continuing half-day-a-week basis. Officers of the Ontario Probation Service comprise one workshop, and 15 clergy representing five denominations in the Toronto area constitute the other. Additional workshops are in the planning stage in Toronto and at branch locations.

Addictions



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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (925-8951)

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A.H.t. Addictions

WINTER, 1961

WHAT DOES IT MEAN?

Over the years since the Foundation first used this circular symbol as an identifying mark on publications and signs, many questions have been asked about its meaning, and some jokes have been made about it. Perhaps it is time to set the record straight.

It was back in 1953 that the then four-year-old Alcoholism Research Foundation felt the need for a distinctive letterhead design and an identifying symbol. An outstanding commercial artist with trademark experience was consulted and he developed a dozen different visual interpretations of the concept the Foundation wished to convey. The concept?—That of an organization that is trying to help people meet life's difficulties more adequately and without the very real danger of becoming excessively dependent upon the organization or its personnel. Also we wished to communicate a "modern" feeling, a sense of the Foundation's work being up-to-date and scientific. (This is why we sought an artist with a modern rather than more traditional approach.)

Many variations on this design were put aside—some because the hand was too-protective, too-supportive, even smothering. The one chosen tries to say that the Foundation is here to offer help as needed, when needed in the course of a growing life.

Teen-Age Drinking Offenders Helped By Unusual Community Club Program

KITCHENER-WATERLOO, a twin city of 93,000 population in central Ontario, boasts a very exclusive club with a high-sounding name — The Orthoscopic Club. Preferred style among members runs to tight trousers, black leather jackets, and ducktail haircuts. The language at their weekly Monday night meetings would scarcely do credit to a tea party. And membership is very restricted — to young men living in Waterloo county, under the age of 21, who have been up in court on illegal drinking charges.

"Orthoscopic" means "giving an image in correct or normal proportions", and that is precisely what Probation Officer Bud Weiland and Magistrate A. D. Barron have sought to give some 400 young probationers who have been processed through the club since it was originated four years ago. They have tried to help these young men to see the world around them and their own place in it with less distortion. "Orthoscopic" also means "giving a flat field of view", and this fits the way the club sponsors talk with the boys — they always try to level with them.

The fact that "orthoscopy" works is attested by the record over four years. Only five per cent of the 400 members have had to be returned for a second try at the six-month course.

It is really a course, or several courses, in learning to live in decent society with a minimum of friction and a maximum of satisfaction. Over the six-month period they enjoy a guest membership in the Y.M.C.A., arranged through "Y" Secretary Joe Connell; they can take a five-week radio-building course through the co-operation of Dominion Electrohome Industries Ltd.; they organize basketball, baseball, and hockey teams and participate in regular community leagues; and — a favorite with many of the boys — they go down to the local police station to take a 14-week typing course (sometimes with the policeman who arrested them sitting beside them as a fellow student).

This realistic program was originally organized with the focus on alcohol problems exclusively. Probation Officer Weiland and Magistrate Barron soon saw that this was no

enough. These young people showed an overall deficiency in social training; and it was seen that their trouble with the law could be turned to advantage and used as a lever to move them over into more constructive channels of activity.

"What was needed was a program that would give a second chance to kids not caught in the stream of the educational system or a healthy home environment," Magistrate Barron says. "They don't need just supervision and talk, but practical help in things like finding a suitable job, how to apply for a job, and how to improve their relations with family, employer, and society in general."

"A typical youngster coming before the court doesn't belong to anything," sums up Mr. Weiland. "He has missed his connections all the way along the road and is well on the way to serious trouble. Our Orthoscopic Club tries to give him the social skills he just hasn't developed up to that time, and an opportunity to establish himself in normal life. We don't look for the bad in a boy. We look for the good and try to develop it."

The broad approach is taken, because it is needed; and dangers inherent in the misuse of beverage alcohol are also stressed, because this is needed too.

Here is the way a form letter to probationers from Magistrate Barron begins: "The purpose of these meetings is to explain to you that alcohol is an anaesthetic and not a stimulant, as you probably believe. Also, the purpose is to impress upon you three dangers inherent in drinking. Probably you have never given these dangers any thought:

"(1) The danger of becoming an alcoholic.
"(2) The danger of driving a car while under the influence of alcohol.
"(3) The danger of being responsible for the birth of an unwanted person into this world . . ."

That's the way the Orthoscopic Club leaders talk. They know that teen-agers often feel that adults don't level with them, so they always lay it right on the line in unmistakable language. And it gets across.

The Orthoscopic Club gets its financial support from the city's Federated Charities and the Kitchener-Waterloo Kiwanis Club. And it has the active support of Magistrate J. R. H. Kirkpatrick and Police Chief John Patrick, as well

as of other community leaders such as Jack Hutchison, a Waterloo businessman, and Rev. Fred Faist of Zion Evangelical Church.

The orthoscopic concept is proving itself in Kitchener as a means of preventing alcohol problems and other costly social difficulties, and other cities are beginning to hear about it and to look for ways in which they can adapt it to their own needs. ◄

An Alcohol Education Package Now Available To Ontario Teachers

THE Alcoholism and Drug Addiction Research Foundation can now for the first time offer to teachers a complete "alcohol education package". This comprises the new film, "It's Best To Know", starring Steve Allen; the Alcohol Studies Guide, prepared by the Foundation for the Ontario Department of Education and recently distributed by that department to high school teachers across the province; and a 32-page, four-color, illustrated booklet for students, entitled "It's Best To Know about Alcohol". A little discussion guide is also included with the film.

To Reduce Confusion

This alcohol education package is designed to reduce the confusion which has beset teachers in times past as they were subjected to the claims and counter-claims of those who sought to use the schools for the propagation of favorable or unfavorable beliefs about beverage alcohol.

In his foreword to the Alcohol Studies Guide, the Hon. John P. Robarts, Prime Minister of Ontario and Minister of Education, speaks of the urgent need to reduce the prevalence of alcohol addiction in Ontario and to overcome "other social problems which may be attributed in part to the uninformed use of alcohol". He notes that this guide "contains an objective and impartial examination of many aspects of the use and effects of alcohol", and commends it to teachers "not as a text-book, but as a source of reliable, factual information on which study and discussion may be based".

Two Suggested Objectives

In an opening chapter which views the whole subject in perspective, the guide suggests these two objectives for classroom work in this field:

1) To let students know that there are many different reasons for drinking or for abstaining from the use of alcoholic beverages, and that there are many different ways of using and regarding such beverages other than those seen in the student's own home and among his particular group of friends.
2) To make it clear that there are recognizably dangerous ways of drinking which affect people of all ages.

The "It's Best To Know about Alcohol" booklet, in colorful comic-book style, endeavors to strike toward the same objectives. It begins with that famous line from the World Health Organization film: "Alcohol means many things to many people . . . the question is, will alcohol control us or will we control alcohol?" There follows then a brief historical review of alcohol usage down through the ages and in other parts of the world. The relative strengths of various drinks are discussed, as are the physical and behavioral effects of various concentrations of alcohol in the blood, alcohol as a food and as a medicine, its role in relation to athletics, traffic accidents, and various social situations. Intoxication and alcoholism are both dealt with, and a helpful, hopeful attitude toward alcoholics is delineated. It is pointed out that not enough is yet known about alcoholism, but that progress is being made, and that with increased emphasis on research and more training for those professions who help the alcoholic, "the epidemic proportions of this disorder can be reduced".

Restore Faith in What Is Said

The tone of the whole book is established by a quotation from the Bracken Commission which is quoted on the inside front cover: "Make known the truth about liquor and thus explode the myths and folklore and unfounded propaganda on both sides of the liquor problem . . . Maintain an informed public opinion based on the lessons of experience and the facts of science. A restoration of faith in what is said about liquor is long overdue."

As a means of introducing this comic-style manual about alcohol to the widest possible use in Ontario, "comic strips" based on its pages are currently being offered to daily and weekly newspapers across the entire province. Response from editors and publishers at press time already promises wide coverage. ◄

Some Educational Implications in the Problem of Drug Addiction

*by Robert D. Russell, Ed.D.**

"In view of the discouraging prognosis of primary drug addiction, good prevention may be the best means of treatment . . . complete eradication of the evil is a commendable but probably unobtainable goal . . . Because the causes of drug addiction are multiple, no single approach to prevention can possibly be successful . . . although education is certainly no panacea for the prevention of drug addiction, the school is the best equipped and most strategically located institution for undertaking preventive instruction."

THESE ideas, abstracted from the last chapter of D. P. Ausebel's comprehensive little book, *Drug Addiction: Physiological, Psychological, and Sociological Aspects,* effectively and tersely introduce us to a problem with which we are concerned but which we face with varying degrees of rigor. In simplest terms, youth—in some numbers and in some places in this country—are beginning to use drugs to which they become habituated or truly addicted; and, in addition, this use begins while the young person is still in school or very shortly after leaving. The problem is indeed an extremely complex one. We see that a number of drug substances are being used as "reality modifiers"; we see this use most often undertaken by youth with noticeable personality problems. Also we recognize that most extensive use is in deprived areas—among unassimilated non-whites, for whom reality is *not* fraught with future prospects for health, wealth, success, and happiness. It is often confusing to attempt determination of the extent to which it is an individual and/or a social problem—a medical and/or a criminal problem.

But our concern is with education, and so let us risk a too-sketchy introduction to the "facts" about drug use and turn to the ways in which education is pertinent. (Since virtually nothing has been written about the educational responsibilities in this subject area for over five years, the author approaches this task with a certain pioneering spirit.) This education has three focuses, which are: (1) to prevent addiction in those who potentially could become users, (2) to develop understanding

*Dr. Russell, who is assistant professor of Health Education at Stanford University in California, first published this paper in the May, 1961 Bulletin of the Association for the Advancement of Instruction about Alcohol and Narcotics. It is reproduced here with his permission.

of the personal and social aspects of the problems within the majority group who probably will never be confronted with the personal choice, and (3) to provide the addict with some perspective on his problem and help him to see alternatives to his past course of action. The first two fall within the province of the school, while the third is more of an individual or small group endeavor within the hospital or penal institution. Let's address ourselves to the school's potential contribution, trying to see possibilities *and* limitations.

ducation Can Help

Can addiction to drugs be prevented by education? This is a question not answerable with the scientific surety of "Can fluoridation prevent tooth decay?" or "Can Salk vaccine prevent polio?" What can education (specifically instruction) do? We employ logic, and we approach the task with much faith, for we recognize that our means for evaluating something as interwoven with other societal pressures as is classroom instruction are not yet precise enough for the answers we desire. But from what we do know about youngsters who become addicts through social pressure, we see ignorance and misconceptions as pillars to the process. For youngsters, then, who become addicted through lack of knowledge of drugs and their consequences or through inability to counter the claims of "pushers" regarding expected effects, education *can* be a major factor in prevention. From another standpoint, teenagers often deal with each other from a position based on misinformation, prejudice, and suspicion; education which helps those who will not become addicted to see more clearly the problems of the "potentials" may assist in creating an environment which accepts more and rejects less—and saves some from turning to drug use. To the extent that reality can be truly improved for some young people, their need for an intravenous modification is greatly reduced.

equirement or Opportunity?

A typical state law (California) reads, "instruction shall be given in all grades of school. . .upon the nature of alcohol and narcotics and their effects upon the human system as determined by science." Thus, the first decision which school administrators and teachers must make is the extent to which actual classroom practice will conform to the letter or the spirit of the law—or, in question form, is this to be considered a "sticky" requirement which can be fulfilled with one short lecture or is it an opportunity for genuine, useful learning? Mr. Harry Anslinger, Direc-

tor of the Federal Bureau of Narcotics, has repeatedly spoken against education about narcotics in the schools, on the grounds that it stimulates curiosity and encourages young people to experiment with drugs. He has been supported in this stand by some members of the U.N. Commission on Narcotic Drugs; still, no evidence has been presented to show that this actually has happened. So, in the light of the earlier comments on the need for faith in the outcomes of education, we are left with a fairly free choice as to whether we see knowledge as primarily a stimulator to tabooed action or as a deterrent to such behavior.

If our answer is to tackle this area with vigor, then we still must choose a *primary* emphasis: the drugs and their general effects on the human system (as stated in the above law) or the personality who is most susceptible to addiction. Lasagna, von Felsinger, and Beecher, a trio of Harvard Medical School researchers, undertook studies in 1955 to test what they felt were oversimplifications and generalizations by textbook writers—that morphine and heroin produced certain set effects evident in all persons at all times, or at least in most persons at most times. They showed that, at least in the laboratory situation, heroin and morphine were not pleasant drugs to the majority of subjects and therefore presumably would be self-limiting. Yet the instructional approach used most often has been a descriptive look at the drugs and the generalized reactions that should be elicited by them.

An Image of Inadequacy

Sometimes our sights and insights can be stimulated by someone who responds to our problems from the perspective of a different discipline. Dr. John A. O'Donnell, Chief of the Psychiatric Social Service at the USPHS Hospital at Lexington, Kentucky, was asked recently for his observations on the values of education about narcotics and his thoughts as to its goals. He responded:

> *"Partly because of the possibility of negative effect and partly because I am dubious of the value of teaching facts about narcotics, my personal feeling would be to avoid any direct focus on narcotics. There is every reason to believe that any program which had general preventive value in the mental health field would have preventive value with regard to addiction specifically . . . If I were responsible for (such a) program, I would tend to avoid facts and focus on structuring attitudes . . . The first use of narcotics necessarily occurs in people whose attitudes about narcotics are not negative, or whose attitudes toward seeking thrills are positive . . . I would attack the mythology that drug use is somehow connected with sexual activity and picture the addict as a person who is very inadequate in his relations with the opposite sex. I would avoid anything that would picture the addict as a rebel against society and try rather to picture him as someone who is so helpless that*

he must give up and run away from reality . . . If the addict is pictured in this way, inadequate, dependent, the vast majority of adolescents would regard him as the last type of person in the world that they would want to be."

So speaks a psychiatric social worker, voicing the need for emphasis on the personality which is or becomes addicted, rather than the focus on the drugs and their general effects. (As educators we should seek views such as this, but we still retain the responsibility of interpreting them in our own classrooms. No one—educator, psychiatrist, judge, physician—has the *final* answer on education for all, in all places and at all times and age levels.)

even Guides Offered

We see a complex picture, then, of the illegal use of drugs which bring on habituation or addiction, which use, in turn, explodes into obvious personal and social problem behavior. Let us consider seven guides to education in this realm—presented on the premise that instruction in the schools *is* one of the means by which we can reduce our current problems.

1. The problem-solving approach should always be included in the classroom approach to the issue. It can be used alone, for it is, among other things, a means of teaching facts (oftentimes more meaningfully because of the context quality) as well as attitudes, or it can be used as a supplement to a lecture, film presentation, or text and reference reading. In a recent government publication on effectiveness in teaching, evidence was submitted to show that problem-oriented approaches to learning were effective. In referring to the learner it was stated, "The important thing is that in his learning, and in the teaching that accompanies it, the student should inquire into, rather than be instructed in a subject matter. . .it (the teaching) will also have to contrive to send individual students on intellectual errands." A subject such as addiction, which is so related to behavior, should elicit thought, comments, and even arguments from students, rather than being presented as just a body of facts to be passively absorbed.

lany Possible Substances

2. Our total concern must expand from heroin and marijuana to include all "substitute euphoriants" which can cause addiction or habituation. Amphetamine, as a stimulant, (distributed illegally as "bennies") produces decided euphoria in many persons (including youngsters) and can

result in a habituation which is close to addiction. Reports from several parts of the country indicate that use of "bennies" has suddenly grown in popularity among teenagers. In some communities barbiturates too are being abused, with dangerous behavior a frequent result. In the Southern California area several reports of youngsters getting "high" by sniffing airplane glue show that ingenuity combined with "need" can result in yet another new problem for the community. Thus, though heroin and its most frequent precursor, marijuana, presumably produce the most untoward effects, we must be aware of—and extend our teaching to include understanding of—the other substances which impair judgment and result in bizarre, antisocial behavior. It is true that there is a medical distinction between addiction and habituation but this should not be the highest priority topic for the teacher; if a student is caught stealing, is frequently truant, is belligerent or inattentive and lackadaisical in learning, then is it exceedingly more important that he is taking heroin rather than marijuana or cocaine?

Link Alcohol and Narcotics?

3. Alcohol and narcotics should be treated as separate areas of study, and caution should be exercised in linking them too closely together in the curriculum. Obviously the State law, previously quoted, does treat them as parallel problems, presumably on the basis that both are evils, and if a teacher links the lesser evil (alcohol) with the greater evil (narcotics) this will result in less use of alcohol. Research in education, however, is beginning to show us that rather gross distortions may take place between what the teacher intends and what any individual student grasps. Thus, the danger of associating them may be in fostering, inadvertently, the notion that "alcohol and narcotics are alike, and I see people drinking alcohol all the time, so narcotics can't be so bad." A teacher can be accurate in pointing out that alcoholism represents an addiction as real and as demanding as that associated with the narcotics; yet he must go on to emphasize that addiction is a *certain* end result for the narcotic user, while only one out of 15 or so who drinks experiences this "slavery" to alcohol. (This is essentially why alcohol is a legal beverage, while narcotics are illegal except as an adjunct to medical care.) Because both kinds of substances produce a "releasing" effect which, in

adolescents, is often painfully obvious in their behaviour, both are illegal for minors. Each is involved in problem behaviors—and these may be similar—but it is also quite important to emphasize how and why they are different.

4. Educators should encourage further study of this complex problem, wherever and however they are able. There are many vital areas of knowledge in conjunction with this issue which are simply blank. A group of researchers met at the invitation of the California State Department of Public Health in 1960 and their report contained this sentence: *"We were individually and collectively appalled,* and I underline this, to learn that studies of the effects of marijuana and other drugs were illegal, and we strongly recommended corrective legislation." Most teachers, in like manner, do not realize that though the information which we convey in our teaching is the result of careful observations of users, it does not come from our most highly accepted scientific procedures. If we are to learn more about the person who becomes addicted—and hence become more able to identify potential addicts—some *controlled* studies eventually must be done.

ducation Research Questions

Further research certainly needs to be done in education about addiction. What elements can be taught effectively by lecture, demonstration, or film with large groups? How should small groups be used and of what size should these be? What elements can be "programmed" for independent learning? How does "programming" affect attitudes? Classroom teachers may not be equipped to do or be interested in doing research, but they should be aware of the lacks and be willing to cooperate with attemps to find new answers.

A Special Study Commission on Narcotics was appointed by the Governor of California last year; the group submitted its first interim report on December 9, 1960; at the conclusion of its twenty-two recommendations was the following guide for the future: "The Commission will particularly continue its studies concerning the adequacy of our present laws relative to treatment, control, prevention, and education and their effect upon the illegal traffic in narcotics in California." Educators in the West should be much interested in the recommendations and the evidence presented

in their final report, which will be submitted before June 30, 1961. Educators in other sections of the country should be aware of similar attempts to gather facts about this problem.

Actually the California Commission was instituted because of pressures from individuals, groups, and the mass media. In the Los Angeles area the newspapers and the radio and TV stations have been working for nearly two years to ferret out facts about the occurrence of addiction and to alert the public. Teachers can use and even help direct these efforts, and certainly should encourage students to consider and evaluate them.

Balanced Presentation Needed

5. Educators should establish better communication with both medical and law enforcement personnel concerned with addiction. Law and medicine often disagree on the nature of the problem and on whether or not it should be part of the school curriculum. The teacher who directs the learning of young people on this potentially crucial subject can increase his or her perspective by keeping in touch with the opinions and experiences of these other differently trained yet equally concerned people. The teacher will use caution, then, in having a narcotics officer or a psychiatrist make the only presentation to students, for students should be made aware of the divergent views of the problem. Again, the teacher must maintain the responsibility for a well-rounded learning experience.
6. All students above grade six should have some planned, curricular learning experiences in relation to narcotics and addiction, irrespective of the actual problem in the community. The known geographic mobility of the American population tells us that a youngster cannot be educated simply for one community; a new student who enters a school in a community with addiction problems may find that loneliness combines with ignorance in some unfortunate ways. In addition, understanding of the problem by those who will not themselves become addicted is fundamental to any meaningful solution. The basic point is that ignorance and non-appreciation of such a social problem as this —even though the problem may not be evident in each hamlet and suburb—is never to be valued.
7. Lastly, in conjunction with the final idea in the previous

point, we need more understanding counselors as vital factors in an educational system which helps to produce people who are more loving, understanding, and accepting. Certainly there is disagreement as to whether the schools should actively attempt fulfillment of such goals —and, if they should, whether they really can succeed. Yet one of the most shameful aspects of the problem is the evidence that addicts who try to "kick the habit" receive very little community support for their efforts, halting and unsure as they may be, and most frequently lapse back to old companions and the "hazy beauty of the stuff." We have the "right" to protect ourselves against societal evils, but we must always match this against our opportunities to understand and help those less fortunate than we—for most of these are not "dope fiends" but rather, in O'Donnell's terms, persons who are helpless, dependent, scared, and inadequate. Mathison ends his chapter on use of addictive substances with a beautiful, yet sad, paragraph:

"Over all the long centuries, men have found no really adequate escape from reality. They can numb themselves, exalt their thinking, create unconsciousness, or dull the drab and gray world about them. They can find monetary relief from pain and—now and again—even more into another plane of life where there are brief ecstasy and the strange wonders of new sounds, sights, and emotions. And when they return, the world is always worse than it was when they left. But, alas, they must always return."

"Just Too Much For Some"

"Life is tough, and those that aren't able to face up to it seek some way out." In a nutshell this is the fact we face. Some persons, early in life, perceive "life" as being more hostile than it truly is, on the other hand, some are born into situations which are "just too much" for the equipment they bring to the struggle. The history of narcotic use, of addictive behavior, is long and varied. We see it as a social problem because it is a source of great social conflict in spots in this country.

Major ports of entry to the country and areas adjacent to Mexico (where relatively low priced barbiturates, amphetamines, marijuana, and heroin are rather readily available) are the areas of greatest concern. In addition, fast-growing, impersonal metropolitan areas are bound to include some unscrupulous physicians, druggists, and other dealers who will supply "needs" for euphoriants. In speaking about growth of this kind, Chief of Police Parker of the city of Los Angeles

was quoted as saying, "It brings a small number of parasites who live off their fellow men rather than with them. It isn't a healthy aspect of growth." Man can serve or can degrade his fellow men.

Education is not the only answer to the problem of addiction; there is no *only* answer. Education can be part of a concerted effort to reduce ignorance of potential effects, increase understanding of the whole problem, and help youngsters to find more truly satisfying ways of dealing with other people and the total environment they perceive. If we abandon our uniquely American educational goal (difficult though it is to attain) of helping each youngster reach his fullest potential—in favor of one concentrating only upon the most academically able—one of the almost certain results will be an increase in addiction. This is one of the hard facts we must face and ponder. ◄

REFERENCES

1. Ausebel, D. P., *Drug Addiction: Physiological, Psychological and Sociological Aspects.* New York: Random House, 1958.
2. de Ropp, Robert S., *Drug and the Mind.* New York: Grove Press, Inc., 1957.
3. Diamond, Murray A., *Drug Addiction and the U.S.P.H.S. Hospital."* Interview with Robert D. Russell, Ed.D., at Lexington, Kentucky, June 23, 1959.
4. Hatch, Winslow R. and Bennet, Ann, *Effectiveness in Teaching.* U.S. Department of Health, Education, and Welfare, Pamphlet OE-50006 U.S. Government Printing Office, 1960.
5. Lasagna, Louis, von Felsinger, John M., and Beecher, Henry K., "Drug-Induced Mood Changes in Man. 1. Observations on Healthy Subjects, Chronically Ill Patients and 'Post Addicts.' " *Journal of the American Medical Association* 157:1006-1020, March 19, 1955.
6. Mathison, Richard. *The Shocking History of Drugs.* New York: Ballantine Books, 1958.
7. Murtagh, John M., *Who Live in Shadow.* New York: Belmont Books, 1959.
8. O'Donnell, John A., "Letter re Narcotics Addiction" Report to the Medical Officer in Charge from Chief Social Worker; included in personal letter from Murray A. Diamond, Medical Officer in Charge, November 16, 1960.
9. Special Study Commission on Narcotics, *Interim Report of the Commission.* Los Angeles, California: State of California. December 9, 1960.
10. von Felsinger, John M., Lasagna, Louis, and Beecher, Henry K., "Drug Induced Mood Changes in Man. 2. Personality and Reactions to Drugs" *Journal of the American Medical Association* 157:1113-1119, March 26, 1955.
11. *Multidisciplinary Programming in Alcoholism Investigation* (A Conference Report). Sacramaento: Division of Alcoholic Rehabilitation, 1960.

Background on the Addicting Drugs Most Frequently Used in Canada

THE vocabulary of the underworld addict offers a vivid and salty picture of the way of life of this obscure group of people. Here are a few of the more commonly used expressions. "Junk" and "white stuff" are generic terms and apply to any of the opiates and sometimes to cocaine as well. Morphine is usually referred to as "M", but may also be called "morph", "Miss Emma", or "gunk". Heroin is usually "H" or "horse" or "Harry". The other opiates, such as codeine, and the synthetics like Demerol and Methadone, seem to have no specific argot names but are covered by the generic terms. Cocaine is usually called "C" or "Bernice" or "Cecil" or by other similar terms beginning with C. Benzedrine is almost always referred to as "Benny" or "pep-pills". There are many synonyms for marihuana, including "greefo", "love-weed", "muggles", "Indian hay" and "Mary Warner". Barbiturates are usually "candy" or "goof balls"; sodium amytal is "blue-heaven", seconal is "red-bird", and nembutal is "nimbie" or "yellow-jacket". A "speedball" is an injection of morphine or heroin mixed with cocaine.

A "joy popper" is a person, not a confirmed addict, who takes an occasional injection of narcotics. Joy popping is usually the beginning of permanent addiction, at which point the addict is called a "hype" or a "hop head". If a person's drug habit can be satisfied by taking drugs orally, he has a "belly habit". A "skin shot" is an injection of narcotics beneath the skin, but when an addict is "mainlining" he is injecting drugs directly into the vein. If an addict needs a "fix" (a ration of narcotics) he usually "connects" with his "peddler" (contacts a retail dealer in narcotics). However, it is quite common for an addict to "throw a Brody", in which he stages a feigned "fit" or spasm to elicit sympathy and perhaps a ration of narcotics from a physician. If an addict is "hooked" (addicted to narcotics) and wants to "kick the habit" (undergo the withdrawal syndrome), he can do this either with the aid of drugs ("tapering off") or suddenly and without drugs ("cold turkey"). The latter is usually called the "iron cure" and is used in many jails and prisons where the addict kicks the habit out on the floor of his cell.

HERE is a summary of background information about the principal drugs used by addicts in North America today. All of the drugs listed below are potentially dangerous, although there is still considerable disagreement about their comparative addiction liability. In the course of medical practice, most of these drugs (with the exception of raw gum opium, prepared opium for smoking, and heroin) are prescribed for legitimate medical purposes. On the whole, there is little danger of addiction in the use of any drug when it is properly supervised by a competent physician who knows his patient well. It is the improper use of these drugs that causes the problems.

The Opiates and Synthetic Equivalents

Opium comes from the milky juice of a species of the poppy, *Papaver somniferum,* which is cultivated chiefly in China, Burma, India, Turkey, Iran, and Balkan countries. The juice is taken from the seed capsules just prior to their ripening and, on exposure to the air, it coagulates and turns into a brown or black powder. This is the raw opium which can be turned into lumps, cakes, and liquid preparations. The odor is characteristic and the taste very bitter. Opium is drunk in the form of an infusion, smoked, or taken orally with some other substance such as sugar or coffee. In North America, addicts take it orally, in the form of pills, or by smoking. At the present time, crude opium is of little importance in Canada's illicit market. Its use is limited almost exclusively to small groups of older persons of oriental extraction who smoke it in specially prepared pipes.

Opium is used as the source of material for production of purified forms of opium (laudanum, paregoric, Dover's powder) and narcotic alkaloids, of which the most important are *morphine, heroin, and codeine.*

Morphine is the most important and by far the best known of the opium alkaloids. It is prepared from opium in legal or illegal factories located widely throughout the world. Morphine sulphate, the most common form, occurs as white feathery crystals or as white crystalline powder. It is odorless but has a very bitter taste. Morphine sulphate is sold legally in tablet form and is usually administered orally. Morphine from clandestine factories may be transported or marketed as bulk power, or in cubes, or for sales to consumers in small gelatin capsules. Bootleg morphine is frequently impure, in which case it may be brownish in colour, rather than white, and may contain varying

amounts of diluents such as milk sugar or starch. Addicts usually take morphine intravenously.

Heroin is a white crystalline powder closely resembling morphine, from which it is prepared by acetylation. Because, therapeutically, heroin's value is no greater than that of morphine, and its disadvantages outweigh advantages of use, its importation and manufacture have been prohibited in Canada since 1955. Heroin can be taken orally, subcutaneously, or even sniffed. But it is almost always taken intravenously by addicts. It is about twice as potent as morphine in any given quantity, and this is probably the main reason for its being the foundation of the illicit traffic. Of all the drugs available, heroin appears to be the most commonly employed for addiction in Canada at the present time.

Codeine appears as white crystals of powder obtained from opium or prepared from morphine. Commercially it is prepared in tablets for oral use or for hypodermic injection. Codeine does not appear in contraband traffic except for small quantities diverted from legal medical supplies. It was in fairly frequent use illicitly in Vancouver during the Second World War, but since then addiction to it has become rare. It can be used to support an addiction originally established by other opiate drugs, although very large quantities are necessary to support a full-fledged morphine habit. Since it is also considerably less soluble than morphine, its excessive use is inconvenient and expensive.

Demerol is a white crystalline powder, prepared synthetically which resembles morphine in its use. Abuse of the drug is encountered among members of the medical and ancillary professions. In the lower social groups, heroin is the favored drug; in professional and sub-professional circle, demerol is the most widely used narcotic.

Methadone is a fine white powder, also produced synthetically, with effects generally those of morphine. It is attractive to the addict and supports opiate addiction. Addicts taking it experimentally often identify it as either heroin or morphine. However, outside professional circles, synthetic drugs do not now constitute an important part of the Canadian traffic.

imulant Drugs

Cocaine is extracted from the leaves of the coca plant, a shrub indigenous to Bolivia and Peru, but now produced chiefly by cultivation in Java. It is a white crystalline powder, odorless, with a bitter taste. Legitimately, cocaine is sold in powder form,

in solution for injection, or in tablet form for the preparation of solutions. In contraband channels it is sold as the more or less pure powder. For sale to the ultimate addict-consumer, it is frequently sold in small papers of powder or in gelatin capsules. Addicts take it as snuff, in tablet form, or by injection, the latter being the method of choice. Cocaine is not much used in the illicit market because it is expensive, its effects are shortlived, and often it has unpleasant after-effects, such as headache and depression. Very few Canadians appear to be addicted to cocaine exclusively.

Benzedrine, or *Amphetamine,* which is the official name for benzedrine sulphate, is a white powder put up usually in tablets for oral use or ampules for hypodermic use. It is a synthetic drug which, taken orally or injected, has a direct stimulating effect on the central nervous system. Addicts frequently make solutions of benzedrine tablets and inject it intravenously.

Non-Opiate Sedatives Considered Addicting

Marihuana is one of the many preparations that can be made from the flowering tops of the Indian Hemp plant, and is the only one in common use in North America. The plant grows wild, can be cultivated successfully in most inhabited parts of the world, and is grown illegally on a small scale in parts of the United States. Therapeutically, the drug has no value whatever. It can be taken orally in a variety of ways but, in the western hemisphere, it is nearly always smoked. In Canada, addicts have not so far used marihuana extensively and it does not appear to be a problem here. In the United States it is the object of widespread self-administration for its intoxicating effect. It has become the subject of a very great continuing controversy as to its addiction liability and as a cause of crime.

Barbiturates comprise a group of sedative and sleep-producing drugs derived from barbituric acid. They are usually taken by mouth. Only within the last 15 years or so has Canada been alerted to the serious addicting properties of barbiturates. It is impossible to estimate with any degree of accuracy the number of chronic barbiturate users and barbiturate addicts in Canada, but it is estimated to exceed the number of opiate addicts several times over. Addicts generally prefer the more potent, rapidly acting drugs such as Nembutal and Seconal.

ombinations of Drugs

Heroin and cocaine are the drugs usually combined by opiate addicts — some taking the combination by sniffing it up the nose, but more often by needle. Benzedrine is sometimes combined with barbiturates to mitigate either extreme stimulant or depressant effects. The most frequently encountered combination, however, is that of alcohol taken orally with barbiturates taken either orally or intravenously. The barbiturates intensify the effect of the alcohol and thereby reduce somewhat the expense of continued intoxication. This practice appears to be increasingly common among Canadian alcoholics seen in clinics.

References

Most of the material in this article has been obtained from the following sources:

1. Maurer, David W., and Victor H. Vogel, *Narcotics and Narcotic Addiction*. Charles C. Thomas: Springfield, Iillinois; 1954.
2. MacDonald, R. St. J., Narcotic Drug Addiction in Canada. *Current Law and Social Problems*, 1960, *1*, pp. 162-204.

OUNDATION NEWS . . .

● A two-week **University of Toronto Extension Course on Alcohol Problems** is being planned for next June 18 through 29 by a joint committee of the University Extension Department and the Alcoholism and Drug Addiction Research Foundation. On-campus residence accommodation is being arranged, and the course of study is being developed in consultation with a Scientific Advisory Committee.

Dr. Erik Jacobsen, distinguished pharmacologist of the Medicinalco Research Laboratory, Copenhagen, Denmark, will be one of the outstanding guest lecturers participating in the course. At press time he had just cabled his acceptance of the Foundation's invitation.

The intention is to restrict attendance at the course to those who have a professional interest in reducing the problems involving alcohol which afflict individuals and society. A balance will be struck between basic academic presentations and workshop techniques in which special interest groups can deal with the practical application of knowledge gained.

Further details will be announced shortly. In the meantime, any inquiries about the course should be addressed to **Gordon M. Patrick,** Assistant Director of Education, Alcoholism and Drug Addiction Research Foundation, 24 Harbord Street, Toronto 5, Ontario.

• **Dr. Mary Purdy,** formerly clinic director of the Hamilton branch of the Foundation, has been appointed Branch Director; and **R. Hartley Beattie,** M.A., B.D., social worker with the Hamilton branch, has added to his duties the role of Supervisor of Education.

• The Foundation has added a $9,200 extension to the research grant made to **Dr. P. E. Ireland,** Professor of Otolaryngology, University of Toronto, for his investigation of alcohol and vestibular function.

• **Dr. Hugo Solms,** visiting research fellow with the Foundation in Toronto for the past six months, has returned to his duties as psychiatrist with the Universitatspoliklinik, Bern, Switzerland. Dr. Solms is a member of the Swiss National Committee on Mental Hygiene and of the Federal Commission on Alcoholism.

• Thirty-three Ontario physicians attended the third annual **seminar on alcoholism for physicians,** sponsored jointly by the Alcoholism and Drug Addiction Research Foundation and the College of General Practice of Canada, November 24 and 25. More applications were received than could be accommodated, and Dr. John D. Armstrong, ADARF medical director, is anticipating the need for an additional seminar next spring to meet this demand.

Special guest participants in this past seminar were Dr. H. E. Peart, assistant medical superintendent, The Mountain Sanatorium, Hamilton, Ont., Dr. David S. Sherman, superintendent and medical director, Sanatorium Division, Department of Hospitals, Boston, Mass., and Dr. E. M. Jellinek, research consultant, Alcoholism & Drug Addiction Research Foundation.

Those attending included public health and industrial physicians, psychiatrists, and tuberculosis specialists, as well as general physicians.

• **Miss Jane Rittenhouse** of the Foundation's education department has been directing a stepped up educational program in the field of nursing. Mass mailings have been made of material specially prepared for schools of nursing, public health, and occupational health nurses, and workshop sessions have been held for three Toronto hospital schools of nursing, a Toronto branch of the Victorian Order of Nurses, the staff of the East York-Leaside Health Unit, and a London area public health nursing group.

Addictions

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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (365-4545)

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Addictions

SPRING, 1962

"You're hooked up with AA, aren't you?" or "You work at that AA clinic, don't you?" — such queries are often heard by staff of the Addiction Research Foundation. They betray a lack of knowledge of the nature and traditions of Alcoholics Anonymous.

To further understanding of this remarkable fellowship of recovered and recovering alcoholics, ADDICTIONS is reproducing in this issue a series of questions and answers compiled and approved by the General Service Conference Study Committee on AA's Relations with Outside Agencies, 1960-61. This is one "outside agency's" attempt to reduce the confusion.

The Addiction Research Foundation enjoys a very happy working relationship with many individuals who are members of AA. A great many patients find their way to our clinics with the aid of former patients who have become members of AA. A loyal and hard-working AA committee has for years provided speakers for special meetings of clinic patients twice each week; and AA and Al-Anon members have often participated in our professional training workshops. We enjoy a long history of excellent two-way cooperation; and one of the chief reasons for this has been the Foundation's respect for the Twelve Traditions of Alcoholics Anonymous. The application of these is made clearer by the article which follows.

"Co-operation: Yes — Affiliation: No" AA's Answer To Outside Agencies

At the heart of AA's success is a simple human contact, one alcoholic to another. The real magic of AA is that these two are able to meet on even terms and to communicate understandingly and effectively.

The growth of AA — to more than 300,000 members in some 85 countries — is merely an extension of this simple man-to-man, woman-to-woman human contact.

If AA were to affiliate with even the most worthwhile institutions or to engage in any outside enterprise, we would find that AA itself begins to be identified as an "institution" or an "enterprise", smacking of officialism.

AA's need for this simple person-to-person image is paramount. It warns the Fellowship that it must resist all impulses to become specialists — to gain worldly status — to seek material help for alcoholism.

The Twelve Traditions of Alcoholics Anonymous reflect the trial and error experience of thousands of groups in many countries over a period of 25 years. They are the basis of the informal but stable structure that has enabled our Fellowship of recovered alcoholics to carry the AA message convincingly to tens of thousands who have sought our help.

The questions and answers which follow are presented as a practical guide for AA members and groups in cooperating with others within the framework of our time-tested Traditions. In fact, we might remind ourselves continually of the following principle: "Cooperation: Yes — Affiliation: No."

(1) Does AA have a specific position in its relations with outside agencies?

Yes, from the beginning AA has cooperated with outside agencies to help alcoholics recover. However, in lending its co

operation, AA has been guided by the principles that serve the best interests of the movement as a whole — by the Twelve Traditions.

In 1959, the General Service Conference passed a resolution in which it expressed appreciation to the various agencies dealing with alcoholism as well as a willingness to cooperate with such agencies, short of affiliation. The resolution pointed out that the movement should be mindful of its Seventh Tradition which states that every AA group should be fully self-supporting declining all outside contributions.

However, the resolution stated that members, acting solely as citizens, do take positions with outside agencies but in no way acting or speaking as representatives of Alcoholics Anonymous.

(2) Should AA affiliate with agencies engaged in the alcoholism field?

No. AA does not affiliate with any outside agency, though it can be grateful for every agency or method that tries to solve the problem of alcoholism. AA members should feel free to participate in the program of an outside agency provided they act as individuals only.

(3) May an AA member serve with an outside agency?

Yes. Individual AAs do so within the traditions as long as they do not exploit their AA membership or disclose it at the public level of radio, TV or the press. Individual members are employed by public commissions on alcoholism and serve on voluntary committees related to an institution or program. However, they are not identified publicly with AA, even though their service — paid or voluntary — may have resulted directly or indirectly from their familiarity with the AA program.

4) Should AA recommend candidates for jobs in state, municipal and industrial programs?

No. AA itself does not make such recommendations. However, individual members may be asked to recommend an AA for

employment in the alcoholism field. It is made clear that the recommendation is made unofficially — and not in the name of AA. It is well to clarify this policy in the beginning to avoid misunderstanding.

(5) To what extent should AA members, working in State Commissions and other agencies in the field of alcoholism, do 12th step work in connection with their jobs?

Twelfth Step work is an AA service and it is AA tradition that members do not get paid for 12th Step work. It would be up to the individual AA member employed by an outside agency to keep his activities as an employee in the field of alcoholism separate from his activities as a member of AA.

Agencies working with alcoholics frequently refer them to an AA group. If the employee of the outside agency happens to see or meet with the same individual at an AA meeting, this would be 12th Step work outside of his regular job.

On the other hand, AA members may sometimes refer an alcoholic unable to accept AA to other related agencies for further assistance. This mutual cooperation leads to harmony and greater help for both.

(6) Does an individual AA member work for legislation pertaining to alcoholism?

An individual AA member, may as a citizen, take any action he desires in drafting, promoting, supporting or lobbying for any legislation he thinks wise, but in keeping with our Sixth Tradition he does not involve his AA membership or in any way appear to speak for AA as a whole.

AA, as a Fellowship neither endorses nor opposes any causes no matter how worthy. Bill W., our surviving co-founder, has this to say: "I think legislative committees are entitled to the benefit of our experience and to our suggestions respecting new ventures and improvements. But let us be sure that such advice is informal and off the record. Let legislators know that they are

receiving the personal opinions of intelligent and experienced AAs who cannot possibly represent AA as a whole".

(7) Should the name of AA be designated specifically in legislation?

No. The name of AA should not appear in legislation. As a movement, AA never tries to affect legislation in any way whatsoever. One of AA's strongest traditions is to avoid all political activity. However, AA members, acting as recovered alcoholics, may cooperate to the extent of being available to legislators for counsel.

(8) Should AA participate in publicity and other activities jointly with an outside agency?

No, experience has shown that it is better not to have joint publicity, for there will be uninformed persons who will be inclined to believe that AA is affiliated with, or is sponsored by, the other organization. Even if the non-affiliation of AA is clearly stated, confusion and misunderstanding may still result.

9) When AA's name has been linked with another agency, for the purpose of fund raising, what may an AA group or central committee do?

It immediately attempts to sever that link. AA Traditions and their importance to the unity and success of AA are explained to the agency. Most agencies are glad to cooperate. But, if necessary and as a last resort, a public statement of AA Traditions is made. This statement is made in general terms to avoid any appearance of public controversy.

10) What precautions should an AA member take when telling his personal recovery story at non-AA meetings?

(1) He mentions the fact that he speaks for himself only, not for AA as a whole.

(2) He usually reveals his first name only, both personally and in any program or publicity.

(3) If he has become known in the community as a member of AA, his membership might be revealed by the press, even though the member hasn't mentioned it. To prevent this, the AA member clarifies the AA Tradition of Anonymity with the people arranging the meeting.

(4) If there is publicity involved, caution is taken not to link the AA name with the activities of other agencies.

(5) If the AA member has any doubts about the wisdom of speaking at a specific non-AA group, he consults the local group or Central Committee before accepting the invitation. (See Tradition No. 4.)

(11) Should activities not part of the AA program be publicized through group meeting announcements, local bulletins or special mailings?

This is a matter for group or central committee decision — but experience teaches us that this is a delicate area. Therefore such activities should not be made a part of group or central committee programs without first consulting the group conscience. In any case, complete clarification is needed to avoid any appearance of affiliation or endorsement.

(12) Should group meetings be held on the premises of an agency in the alcoholism education field?

No. Experience shows that when AA meetings are held on premises occupied by agencies in the field of alcoholism education confusion arises as to AA's relationship to such agencies and as to the purposes of each.

Traditionally, AA cooperates with all such agencies but does not affiliate or lend the AA name.

Since both AA and these other agencies concern themselves with the problem of alcoholism, it is easily seen how confusion can arise when AA meetings are held in such facilities. (See also Question No. 16.)

(13) Do AA groups, intergroups or service committees ever refer alcoholics or their families to outside agencies?

Yes, such a referral is made provided that problem involved lies outside recovery through the 12 Steps of AA. (See also Question No. 5.)

(14) What is the relationship of AA members, groups or central committees to hospitals, rest homes and other rehabilitation aids in the community?

Experience shows that AA groups and Intergroups or Central Committees should not operate or manage these ventures. Individual AAs frequently set up such related facilities, being careful not to use the AA name in general in solicitation, advertising and publicity. These ventures are usually set up on a non-profit basis, incorporated under the charitable and educational laws of the state and excluding "Alcoholics Anonymous" from their names.

Hospitals and rest homes and other community rehabilitation aids bear the same relationship to AA groups, Inter-groups or Central Committees as do any other outside agency. With full co-operation of the groups in the community, they are used for referral, provided AA's Tradition of non-endorsement and non-affiliation is made clear.

Since these ventures are separate from the Fellowship it is advisable that they operate under names which do not link them to AA — under names *other than* "12th Step House", "Alanon House", etc.

15) Should a club for AA members, separately incorporated under a name that does not include "AA" or "Alcoholics Anonymous", accept money from a foundation or from non-AAs to purchase a new building?

No. Since a club is frequently known as an "AA Club" even when it is incorporated separately, experience shows that it is wiser to accept the financing on a loan basis. This is in keeping with the spirit of AA's Seventh Tradition of self-support.

(16) Should AA groups hold meetings in hospitals, rehabilitation centers, rest farms or alcoholism clinics?

Yes. In cases where the group is provided with a meeting place, literature, coffee, refreshments and help in preparing and distributing a newsletter, the immediate aim of the group should be to make itself self-supporting. This is in line with AA's Seventh Tradition, "Every AA Group ought to be fully self-supporting, declining outside contributions".

Where this is difficult, AA groups in the area are called on to help, thus obtaining AA cooperation rather than depending on the related facility.

In keeping with AA's Sixth Tradition of non-endorsement or lending the AA name to any related facility, it is suggested that the group select a name which would not link AA with the name of the facility.

(17) Should AA groups accept financial help from outside sources? For example: literature, free rent or other financial help from a non-member, government commission on alcoholism, or any other outside agency?

No, they should not. In line with AA's Seventh Tradition: "Every AA Group ought to be fully self-supporting, declining outside contributions".

If any particular group finds it a hardship to secure literature, the General Service Office makes every effort to help. All new groups receive a complimentary supply of literature from GSO. If literature is accepted from an outside agency, it might be on a loan basis, paying back as the literature is sold.

If a meeting place is offered at no charge, it is customary for an AA group to make a small monthly contribution to take care of extra janitor services and electricity, or to make an annual donation to the landlord.

(18) How can a non-alcoholic be of assistance in starting an AA group?

By definition, AA is a fellowship of alcoholics. However, it is sometimes difficult to find an available alcoholic to help start a group.

In this case, if a non-alcoholic helps in the formation of a group, he should receive the thanks of the group — and a standing invitation to attend all open meetings.

(19) What is AA policy in regard to a judge (or other government official or agency) ordering an alcoholic to attend meetings as a condition to receiving a suspended sentence or parole?

AA is a voluntary program and our experience teaches that, as a rule, alcoholics resist accepting AA under duress.

It may be helpful for groups or local committees to explain this to the official — depending on his previous relations with and understanding of AA.

Also, it should be made clear that Groups and Committees are eager to help in any cases referred to them. However, they cannot accept responsibility for the alcoholic's sobriety or good conduct.

Groups and Committees should avoid entering into controversy with an official regarding decisions which, in the final analysis, are his and not those of AA.

(20) What action should be taken in cases where serious differences arise between an AA group or central committee and government or private agency dealing with alcoholism?

An appropriate AA Commitee should seek to arrange a meeting with representatives of the outside agency for a frank discussion of the problem. Finding a solution depends on a willingness to communicate with one another and AA should not hesitate to take the initiative in any matter affecting the recovery of sick alcoholics.

Past experience indicates that seeming differences have often been based on a misunderstanding of the facts by one or both parties. In other cases, the cause of the difficulty has been

found to be a lack of information — of AA's traditions by the outside agency, for example, or by AA's regarding the statutory restrictions on the operation of a Government facility. Often, an exchange of information and views is all that was needed to eliminate the problem.

For cases involving the use of the AA name for fund raising purposes, see Question No. 7.

(21) When an AA member who is employed by an outside agency speaks at an AA conference or group meeting, should his or her position be mentioned in publicity or on the program?

Not if he speaks as an AA member. The Host Committee or inviting group shares in the responsibility of protecting the member's anonymity in all publicity and programming.

The first name of the AA speaker and his or her group or area are used as identification. Care is taken not to use his title or position with the outside agency.

If the member is not speaking as an AA, but as an employee of an outside agency, then the full name and position may be used. If the speaker so wishes, he or she may also be identified as a "recovered alcoholic," not as a member of AA.

To avoid misunderstanding, the AA speaker consults beforehand with the people arranging the gathering so that any publicity will be consistent with AA's Traditions. ■

God grant me the serenity to accept
the things I cannot change,
the courage to change the things I can,
and the wisdom to know the difference.

AA's Twelve Traditions

(1) Our common welfare should come first; personal recovery depends upon AA unity.

(2) For our group purpose there is but one ultimate authority . . . a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants . . . they do not govern.

(3) The only requirement for AA membership is a desire to stop drinking.

(4) Each group should be autonomous except in matters affecting other groups or AA as a whole.

(5) Each group has but one primary purpose . . . to carry its message to the alcoholic who still suffers.

(6) An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

(7) Every AA group ought to be fully self-supporting, declining outside contributions.

(8) Alcoholics Anonymous should remain forever nonprofessional but our service centers may employ special workers.

(9) AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

(10) Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

(11) Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

(12) Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

Adults and Teenagers Need To Know Addiction Potential in Many Drugs

by A. S. Macpherson, M.D.

The following article comprises abstracts from "What Can We Do About Tranquillizers and Goofballs?", published in the October 1961 issue of HEALTH, bi-monthly magazine of the Health League of Canada. Dr. Macpherson, a research scientist in the Department of Psychiatry, Queen Mary Veterans' Hospital, Montreal, prepared the paper originally for an address to the Rosemere Alliance Club.

The original transquillizer is food. Food is one of nature's sedatives; humans, like many wild and domestic animals, become relaxed, drowsy, and relatively inactive following a good meal. Some people, however, eat in an attempt to relieve anxiety. These people may become addicted to food and subsequently become very fat.

The oldest and still the commonest chemical used in the relief of anxiety is alcohol. It provides a relief of tension, relaxation of inhibitions, and a feeling of warmth and relaxation that spreads throughout the body. This can be an extremely pleasant feeling.

Over-indulgence in alcohol results in an unsteady gait, slurred speech, and slowed thinking. At this stage, alcohol as a poison has effected tranquillization by interfering with the function of the brain. As drinking continues, unconsciousness and even death may result. People who habitually use alcohol as a tranquilizer become alcoholics with all the physical, social, and economic complications of that condition.

Drugs Good and Bad

As time went on, man discovered more and more compounds to enable himself to shut out the terrifying realities of the world.

Each in turn was hailed as a wonder drug. Each in turn demonstrated that desirable qualities, relief of pain, relief of anxiety, and production of sleep were offset by undesirable side effects.

The burgeoning field of chemistry in the 19th century produced such anxiety-allaying substances as the bromides and chloral hydrate — that sweetish, pleasant, swelling substance which added to alcohol became infamous as the "Mickey Finn".

In the 20th century the barbiturates were discovered. These are the most commonly prescribed sleeping pill today, and they have helped millions of people suffering from insomnia. They are used in the management of epilepsy; occasionally they are still used as tranquillizers and sedatives in psychiatry. Most people requiring an anaesthetic are put to sleep with an intravenous injection of barbiturate. They have contributed greatly to medical advance.

Barbiturates are also available illegally at 10 to 25 cents a capsule and are called "goofballs".

Addiction Defined

All the drugs mentioned have the potential of producing a state known as drug addiction. The World Health Organization defines this state as follows: "Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence on the effects of the drug; (4) detrimental effect on the individual and society."

A simpler definition might be that an addict is a person who feels "normal" on drugs.

Danger in Tranquillizers

Herein lies the great danger of tranquillizers. They are almost all potentially habit-forming. Improper use of the common tranquillizing agents can produce drug addiction. The drug addict, whether he be addicted to alcohol, to heroin, to barbiturates, or to other substances has a truly insatiable desire for his "fix". He will give all the money he has, he will steal, lie, defraud, all for that bottle or capsule which brings him relief.

This behaviour is of a different order from that of the person seeking relief from anxiety or the person taking drugs under medical supervision. The addict has a history of prolonged use, gradually requiring increased dosage to achieve the desired effect. Prolonged regular use with gradually increasing dose is the danger sign of addiction

The person intoxicated with barbiturates is rather similar to the person intoxicated with alcohol. He is somewhat drowsy, he is often unstable. He becames unreliable. Such a person is very likely to lose his job and his position in the community. He ceases to care and takes further refuge in the habit.

What About "Goofballs"

The use of "goofballs" has become a serious concern in some Canadian cities and it deserves some attention as a specific problem in addiction. "Goofballs" is a loose term applied most commonly to short-acting barbiturates such as seconal, nembutal, and to a lesser extent amytal. Another form of "goofball" contains a stimulant, dexedrine, along with the barbiturate, producing less tendency to go to sleep.

"Goofballs" are almost always taken by mouth. In order to enhance the effect, some addicts first take an aspirin. Aspirin is *not* a tranquillizer and not a habit-forming drug, but it does irritate the stomach producing increased blood flow to the stomach wall, which in turn helps the other drug to be absorbed more quickly and giving a greater "kick". This works with "goofballs" and it works with alcohol.

Teen-Age Aspects

The use of tranquillizing drugs has social implications in areas other than addiction. In the teen-ager, the "goofball" problem represents a new aspect of a familiar problem. We have always had rebellious teen-agers and we will always have some juvenile delinquents. Rebellion, to a greater or lesser degree, is a part of growing up — part of the process that produces creative and independent men and women instead of submissive, conforming children.

The teen-ager is looking for excitement and new experience when he tries "goofballs". In a way, we should encourage within limits the searching and seeking of our adolescents. The tragedy of "goofballs" lies in the innocent ignorance of the young person. He is unaware of the serious danger to his personality that can result from intoxication with or habituation to these potent drugs. For this reason he must be protected, and this is why we need strict control over the manufacture and sale of these drugs. For some, these efforts are too late; but we can hope to avoid further personal disasters.

Tranquillity Without Drugs

The adult who takes tranquillizers presents a different problem. Anxiety is a natural and inevitable part of life and it can serve a creative purpose. The after-dinner speaker, for example, probably talks better under the influence of some anxiety. Tranquillizers have their place, certainly; but they are not intended for those who seek a chemically created world of tranquillity. They will not provide a problem-free way of life. We should be able to find tranquillity without drugs. The roots of true tranquillity can be found only in home, family and community.

We must meet our challenges even if they make us anxious for a time. We must work to improve community life so that those who are more sensitive to the fears and anxieties of living can gain emotional support. ■

Noah - Satan Drunkenness Parable Helped Strengthen Jewish Sobriety

*By Abraham L. Feinberg**

An alcoholic is not always produced by the fact that liquor is legally available. The era of prohibition, synthetic gin and bootlegging empires scarcely lacked its share of chronic alcoholism. Furthermore, highly scientific probing into the causes of this evil appears to suggest that it issues as much from the psychological and emotional imbalance of the individual as from the customs and canons of society. Often alcoholism is a personal sickness before it becomes a collective sin.

Another conclusion apparently established by surveys is the comparative rarity of alcoholism among Jews. One section of a gigantic research project conducted by Yale University analyzed the drinking habits and predilections of various ethnic and religious groups. The data accumulated over a period of time seemed to bestow the prize for moderation on us; we Jews evidently are the least likely to get drunk, either on a single occasion or on a protracted, chronic binge.

If one may give credence to popular assumptions, this verdict is valid. The infrequency of Jewish alcoholism has almost the force of a dogma. How often my Gentile friends congratulate me on the sobriety of Jews. "I have never seen a Jew get drunk," is the frequent remark, spoken with the utmost sincerity.

An Embodiment of Togetherness

This tribute, I believe, can be justified, with the substitution of seldom for never, and the understanding that it applies to

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* Dr. Feinberg, who is rabbi emeritus of Holy Blossom Temple in Toronto, originally wrote this article for a "Canadians and Their Religion" column in The Toronto Globe and Mail. It is reproduced here by special permission of Dr. Feinberg and The Globe and Mail.

individual drunkenness, not to social drinking. Middle-class Jews regard cocktails, a convivial glass on happy family occasions and communal use of spirituous beverages in the synagogue — when associated with religious ritual — a routine embodiment of the pleasures of togetherness.

Some evidence can be adduced for the suspicion that during recent years Jewish indulgence in hard liquor has grown from a natural expression of gregariousness, and gratitude to God, into a tyrannical habit. Scotch and rye at a bar replace sacramental wine at the family table — and the change is not always an improvement.

In view of the great increase in the use of whisky among Gentiles generally, however, the reputation of the Jew for restraint, by comparison, has not yet been forfeited. The tradition of Jewish sobriety is intact.

Less Moderate Eaters

A spate of learned articles has been written of late to explain the resistance of Jews to intoxication. Before suggesting my own theories, I must, in all fairness, admit that an examination into eating proclivities, rather than drinking, might yield a contrary result. We do not normally imbibe liquids to our hurt, but what about solids? Yale University's glance at the psychological complexes that generate a bottled binge may discover that the Jew's anxieties and frustrations find their outlet in gefillte-fish rather than a gin fizz, in strudel, not schnapps, in a Scotch herring with sour cream instead of scotch-on-rocks, in knishes and kishke. And there were times after a Bar-Mitzvah (confirmation) party when I might have been willing to debate the relative peril to gastronomic stability of the two alternatives.

Why have the Jewish people been less inclined to alcoholism? There are several possible explanations.

First, Jewish teaching penalized over-indugence not only with the retribution of God but the wrath of the community. Ages-

old contempt for the drunkard was illustrated by an ancient Rabbinic folk-tale which goes back to the time of Noah.

Satan's Four Cups

The myth relates that Noah was engaged one day in breaking hard clods of earth, preparatory to planting a vineyard. Suddenly Satan appeared before him. In answer to his diabolic majesty's query about the kind of fruit it would bring forth, Noah replied: "The grape which gives joy to man." "Then let us work together," exclaimed Satan with an alacrity which would have given pause to a man less naive than the ark-builder. In any case, Noah consented.

Thereupon Satan slaughtered a lamb and poured its blood over the soil. He then caught a lion and let the blood drench the earth, thereupon an ape, treating it in the same manner. Finally he slew a pig, and the blood gushed forth to join that of the three other beasts as fertilizer for the ground.

Noah, being human, could stay his curiosity no longer, and implored the tempter to explain. Satan's reply was: "After the first sip of the juice of the grape — one cup of wine — man becomes as mild and gentle-spirited as a lamb. The second cup lends him the courage of a lion, and he bawls menacingly about his might. No sooner does he quaff the third cup than he dances, leaps and bounds foolishly like an ape. At last with the fourth cup, he wallows with a swinish self-degradation in mud and filth."

In medieval Europe, after hard liquor was introduced to wide Continental usage from the fog-draped fens of the northern isles, the ghetto became an island of sobriety in a sea of chronic and sodden drunkenness. Perhaps the legend of the four animals was one of the bits of moralistic mortar which held back the flood waters of pagan libertinism. Certainly no prohibition tract by the Women's Christian Temperance Union would be better calculated to stem the wet tide. Hebrew sages knew that a simple parable can be the most subtle propaganda.

Drunkenness Considered Un-Jewish

My father, a pious Orthodox Jew, always had a modest bottle of schnapps in the icebox. Since Judaism never inflated a drink of liquor into a mortal sin or a mystery, he did not conceal it apologetically from his children. I remember how he smacked his lips after enjoying a tiny tumbler of the familiar amber fluid. We shared that joy, just as we shared the sacramental wine on Sabbath Eve and festivals. But all of us had nothing but the deepest disdain — or pity — for the town drunk.

It was the pride of the Jewish community in its own standards of good taste that strengthened the ramparts against excessive drinking. The Jew deemed himself a member of a moral aristocracy, among whose hierarchy of values were self-respect and self-discipline. Drunkenness was considered un-Jewish, violation of the code.

Sobriety for Survival

And it also jeopardized the existence of a people on the firing line of history. The Jew could not afford the luxury of a soft permissive or frivolous attitude toward drunkenness, because he was marked for hardship, the constant danger of persecution, and dare not weaken his moral and mental fibre with the corruption of alcoholic excess. Destiny compelled him to be stronger than his neighbor in order to survive.

Finally, to match the four animals of the old Rabbinic story, I would list four degrees of inebriation.

The first type of drunk is the jocose, who cracks a stale pun, plays moronic jokes and becomes the (low) life of the party. The second is the bellicose, full of fight, challenging the world to impugn his honor, free enterprise, his political party or opinions. The third is the lachrymose, weeping pink elephant tears over the sorry state of the world and his own soul. The fourth is the comatose, stricken with immobility, and staring through glazed eyes at the empty air. ■

First Decade Points Way To Future For Addiction Research Foundation

Here is a series of notes taken from the hundred-page 11th annual report of the Alcoholism and Drug Addiction Research Foundation of Ontario, which was tabled in the Legislature April 4.
These notes fail to do the full report justice, particularly so in the case of the research department. That section in itself comprises a 33-page comprehensive review of the Foundation's first decade of research. It is a landmark document that stands on its own feet, and as such it will be published separately for those specially interested.
The education department will be pleased to receive requests from interested readers who wish to receive either the complete Foundation report or the "Review of Research 1951-1961". Such requests should be addressed to the Education Department, Addiction Research Foundation, 24 Harbord Street, Toronto 5.

A strong demand for more services to combat alcoholism and drug addiction is reflected in the 11th annual report of the Alcoholism and Drug Addiction Research Foundation of Ontario.

Expansion is called for, particularly in treatment services, professional training, and preventive education, to meet the needs of the province's more than 90,000 alcohol addicts, close to 1,000 narcotics addicts, and an unknown but substantial number of persons addicted to other non-narcotic drugs.

Help for Non-Criminal Addicts

An experimental narcotic addiction treatment unit in Toronto is envisaged, located where experienced staff can be shared with the Foundation's principal alcoholism treatment unit on Harbord Street. It is noted that treatment facilities for non-criminal narcotics addicts are meagre in North America and Ontario has an opportunity to pioneer a project that would enable such addicts

to get help as sick people before they become too deeply enmeshed with the law.

Such a unit should not be totally an out-patient facility because of the hospital care involved in withdrawal of patients from their drugs. On the other hand, withdrawal is only one episode in the course of treatment; and other aspects of addiction may or may not require as much institutionalization and security procedure as one has been led to believe.

It is the Foundation's view that treatment of addiction to drugs other than narcotics can be undertaken in present and proposed alcoholism clinics.

More Alcoholism Treatment Units

The Foundation's alcoholism treatment centres in Toronto, London, Hamilton, and Ottawa perform a limited function in the investigation of treatment methods and in the training of professional people in methods of helping alcoholics; but these facilities were not planned to meet anything like the total need for services. (Together they see about 2,000 patients a year out of a total of 92,000 Ontario alcoholics.) Expanded treatment facilities are required in cities where Foundation branches are already located, and new services are needed in other parts of the province.

Up to now the principal obstacle to expanded development of such services has been a shortage of suitable professionally trained staff. This shortage is gradually being remedied by the Foundation's training activities. (Something like one-third of the psychiatrists in Ontario have now spent some part of their professional training time working in the Foundation's clinics, and other professions have also been involved to a lesser extent.) It seems likely, therefore, that it will soon be possible to staff clinics in two or three additional centres.

Local Initiative in Evidence

It is gratifying to note that in a number of communities where the Foundation does not provide services, a variety of citizens in-

volved in the social services, the judiciary, the clergy, Alcoholics Anonymous, and other groups have been meeting to consider what can be done locally about addiction problems. Over the past year an increasing amount of Foundation staff time has been applied in a consulting capacity to such interested community groups.

Future Development of the Foundation

Future development of the Foundation is likely to take place along two main lines — strengthening and enlarging the central research, clinical training and educational establishment in Toronto; and further development of smaller "satellite units" in appropriate centres. Plans call for consolidation of the Foundation's central offices in one building together with a 60-bed hospital to replace the present 15-bed unit; and also for the development of a well trained staff to be available in other communities to help with the efforts made by local health resources and social agencies.

It has been and it remains the intention of the Foundation to develop and spread knowledge about how to deal with alcoholism in such a way as to have this know-how put into practice by the personnel of health and social counselling resources in every community of the province. Some progress in this direction has already been made: throughout Ontario today there are far more people than ever before who are actively interested in helping the alcoholic and who have some competence to do so.

To Service Only 10% of the Total Need

It should be made clear right from the start that the Foundation is primarily a research, training, and educational organization designed to provide treatment services only incidentally to its broader and more basic purposes. Its direct patient-handling capacity should be limited to servicing not more than 10 per cent of all alcoholics in any community.

Even this 10 per cent will be no small number. One has to think in terms of a potential 100,000 alcoholics in Ontario; and to provide demonstration community clinical services for 10 per cent of these during a year will require about a five-fold expansion of the Foundation's present clinical facilities. A variety of services will have to be established mostly of an out-patient type.

One Unit for Every 150,000 People

In a province of six million people it is considered that there is a need for one clinical unit the size of a present Foundation branch for every 150,000 of population, outside of metropolitan centres, plus a few somewhat larger establishments within the major urban areas.

Such a system of services cannot spring into operation overnight, but it is seen as a target for the next few years by the Foundation. The problem involved is not so much one of bricks and mortar as it is of attracting and training enough suitable professional personnel.

New Summer School on Alcohol Problems

The professional training function of the Foundation devolves upon the education department in collaboration with treatment and research personnel. This takes the form of special short courses, seminars, and workshops conducted at various points in the province throughout the year. Plans have been made this year for a special two-week residential Summer Course on Alcohol Problems at the University of Toronto, June 18 to 29. Special lecturers are being brought from Denmark, California, and Washington to supplement Foundation personnel on the faculty. Registration will be limited to a maximum of 80 participants in this first year.

Education Materials for High Schools

The most important accomplishment of the Foundation's education department in 1961 was the completion of a three-part package of materials for use in teaching grades 10 to 13 in

Ontario high schools. The basic part of this is an "Alcohol Studies Guide" published in collaboration with the Ontario Department of Education and distributed to all high schools for the teachers' use. Complementing this guide is a mass-produced booklet and also an eight minute discussion-starting type of film, both entitled "It's Best To Know". Initial printing of the booklet was 500,000 copies, and the Foundation has already received many requests from other provinces and states for permission to republish it for use in other jurisdictions.

These projects represent the beginnings of an answer to a long-felt need for some means of presenting information on alcohol to young people in a way that will be acceptable to all, regardless of the diverse attitudes held in different homes toward the use of alcohol.

In 1961 the Foundation's education department increased its capacity to conduct seminars and courses for physicians, nurses, social workers, probation officers, clergy, and other interested groups. It is planned to augment both personnel and space to accomplish more of this type of training in 1962.

Researchers Are More Hopeful

The Foundation's annual report for 1961 contains the most thorough review yet published of research into alcoholism undertaken both by staff research workers and on Foundation grants in the universities of the province over the past decade. More than 120 projects are discussed, ranging over 13 different major areas of investigation, and some 250 reports have been prepared.

A trend in the varied research activities of the Foundation really began to crystallize in 1961. The formative and purely exploratory stage of research has come to an end, and a new period has begun in which there is a more precise sense of direction in evidence. This provides a sound basis for a feeling of optimism concerning the future. The chances of acquiring the knowledge necessary to make reasonable headway against these problems of addiction now appear to be much more hopeful than was the case even a year or two ago. ■

Strategic Role Seen For Clergy In Helping Alcoholics and Families

*By Irving Babow, Ph.D.**

That the clergyman may have a strategic role to play in helping alcoholics is accepted by many. Some of the reasons pointing in this direction are these:

(1) There is an increasing emphasis in public health programs for alcoholism control on family-centered and community -centered approaches.

(2) It is acknowledged that there is therapeutic importance in initiating and maintaining appropriate interpersonal relations with the alcoholic and his family.

(3) There is a shortage of professional manpower that is oriented to work with alcoholics and their families; community psychiatric resources are limited and have long waiting lists; and many troubled families are unable to pay the fees of psychiatrists and psychologists in private practice.

42 Per Cent To Clergy

(4) There is evidence that a substantial proportion of the public feels that a clergyman is the person to turn to for help with emotional and mental health problems. (The Joint Commission on Mental Illness and Health reported in its survey of a representative national sample of the non-institutional, "normal" adult U.S. population that 23 per cent of adult Americans have at some time in their lives experienced a serious mental health problem. Fourteen per cent of these have actually sought help, and of these 42 per cent went to a clergyman, 29 per cent to a

* Dr. Babow is a medical sociologist and a lecturer in the School of Social Welfare, University of California, at Berkeley. He is a member of the San Francisco Health Council's Committee on Alcoholism and served as research director of that Council's survey of alcoholism in San Francisco. This paper was given in November 1961 at an Episcopal Church conference on "Pastoral Help in Alcoholic Problems".

non-psychiatric medical doctor, 18 per cent to a psychiatrist or psychologist, and 10 per cent to a social agency specializing in psychological or emotional problems.)

All of this suggests that members of the clergy may have an opportunity to reach families with an alcoholic problem. The hope is that trained people so strategically placed will be able to help at an early stage before serious mental and physical damage has occurred and while preventive measures can still be taken.

Direct or Indirect Help

The clergyman's role may be a direct one with members of the family or with the alcoholic himself, or it may be that he will serve more indirectly as a part of the community's total health resources. His contribution in direct service may be along these lines —

Early detection and case-finding, especially of the "hidden alcoholics," who are likely to be employed and living with their families and who constitute the great majority of North American alcoholics. Only three to 10 percent of alcoholics are estimated to be on Skid Row. Often the overt problems of children of the hidden alcoholic are clues to an alcoholic parent.

Each Is An Individual

Evaluation of the alcoholic and his family with some attempt at assessment of the situation, stage, and potentials. Such assessment requires careful attention to the individual situation and experience and not a stereotyped assumption that "alcoholics are all alike." Since many alcoholics have medical problems related to their excessive drinking, referral to a physician or clinic for diagnosis and medical treatment is often indicated. If the minister believes the person has serious emotional or mental disorders, referral will be encouraged to a psychiatrist or community psychiatric resource. Such referral is especially urgent when the person seems very depressed and a potential suicide.

Referral, whether to any of the above-mentioned resources or any others such as halfway houses or Alcoholics Anonymous. This requires thorough knowledge of community resources and a good relationship with the alcoholic and his family so that the suggested referral will actually be made. The step of referral should by no means be regarded as the final one but is often only the beginning of the minister's helping role. To continue effective aid when other professional disciplines and community resources are involved requires some familiarity with those professional roles and agency programs and establishment of a good working relationship with these other helping persons. Naturally, this means also that the clergyman make clear to them what his continuing role is in the helping process if such continuation seems indicated.

Accept Him As He Is

Individual, family, or group counselling. Such counselling is based in large part on the capacity for establishing interpersonal relationships which will lead to clarification of goals, establishment of a plan and the development of motivation for carrying out the plan. Maintaining sobriety is, of course, a major goal but there may be many relapses if the person remains unable to cope with stresses and problems and requires recourse to drinking. Martin's Buber's concept of an "I — thou" relationship is important so that the alcoholic is not viewed as a passive or generalized object in an "I — it" relationship. The term, supportive psychotherapy, seems appropriate to describe how the clergyman can be especially helpful in his counselling. According to the Harvard psychiatrist, John C. Nemiah, M.D., supportive psychotherapy is "based on knowledge of the patient's character structure and the environmental stress distorting his psychological equilibrium. It accepts the patient as he is, and without attempting to change his basic character structure, is aimed at strengthening his existing defenses, satisfying his needs, and removing environmental stresses."

The clergyman may be especially helpful in such counselling at day care centers, out-patient alcoholism clinics, and at half-way houses for rehabilitation of alcoholics.

The question of motivation is one that is important in helping alcoholics and their families. The sympathy which the clergyman demonstrates, being careful to avoid over-identification and moral exhortation, is an important asset but other things are also involved. As Albert Stunkard, M.D. points out, motivation for treatment requires adoption of an appropriate attitude to one's conditions, recognition that one is sick and something is wrong, that this condition is undesirable and the person is unable to help himself and requires the aid of some qualified person in learning how to get well. According to Stunkard, the final stage in motivation for treatment is that although the individual cannot help himself out of his distress, he recognizes that someone else, who is culturally defined as expert in these matters, can do so.

Help To Avoid Relapse

Rehabilitation of alcoholics who have been discharged from mental hospitals or from correctional institutions and require reintegration into the community. The clergyman can play an important role here in preventing recurrence and readmissions to such institutions by showing the alcoholic and his family that the minister cares about them and wants to continue helping them. The fellowship provided through church activities, aid in getting suitable employment and referral to appropriate vocational rehabilitation and employment services, referral to halfway houses and other facilities such as day care in general hospitals, liaison with other helping persons and agencies, and continuing encouragement and counsel are important factors in the transition back into the community.

Indirect Services

The indirect services in which the clergyman can participate are: (1) Education of the public, starting with his own church membership, regarding alcoholism and the need to help alcoholics,

and sound ways of extending help. (2) Professional education of ministers and of other helping professions so that each one understands the other's role in alcoholism control and that effective team relationships can be developed. Multidisciplinary conferences can be of assistance and so can training in theological seminaries both for students and for post-graduate work. (3) Consultation services on how to assist alcoholics and their families and how to use community resources. Clergymen who are especially oriented in this field can help and encourage other ministers, church laity, and members of other professional groups through consultation. (4) Participation in social planning by health councils, health and welfare departments so that agencies and professional resources in the community have an integrated community program which identifies needs for care, and develops essential services and their integration, and encourages evaluation in order that prevention, treatment and rehabilitation can be made more effective. (5) Encouraging "gate-keepers" and "care-takers" to take a more active role in helping alcoholics and their families. Clergymen, in addition to reaching their own church membership which includes influential persons in the community, often serve as chaplains in various institutions (correctional institutions, hospitals, armed forces, and others) and are in a strategic position to stimulate programs and actions for alcoholism control. ■

REFERENCES

Babow, I. *Report on Alcoholism in San Francisco,* Health Council, United Community Fund of San Francisco, 1959.

Gurin, G. "Mental Health Needs and Their Treatment in the Normal Population, *Proceedings of 1961 Annual Conference — Surgeon General Public Health Service with State and Territorial Mental Health Authorities,* U.S. Dept of Health, Education and Welfare, 1961, pp. 13-23.

Jellinek, E. M. *The Disease Concept of Alcoholism* (New Haven: Hillhouse Press, 1960).

Mann, M. *New Primer on Alcoholism* (New York: Rinehart & Company, 1959).

Nemiah, J. *Foundations of Psychopathology,* (New York: Oxford University Press, 1961).

Stunkard, A. "Motivation for Treatment," *Comprehensive Psychiatry,* Vol. 2, No. 3, June 1961, 140-148.

COFFEE DOESN'T HELP

A report out of New York recently on the Herald Tribune News Service was published in several Canadian papers under some such heading as the above. The report said, in part: "Don't count on drinking coffee to sober up in a hurry after a drinking bout. Two University of Indiana pharmacologists have found caffeine works to prolong the effects of alcohol rather than dampen them . . ."

The report referred to experiments with rats and some subsequent work with human subjects. The tested humans were said to have received about the amount of alcohol they would take and still "consider themselves sober enough to drive a car". Then some of them were given caffeine capsules "containing the equivalent of several cups of coffee". One of the researchers is then quoted as saying: "We anticipated that the caffeine would antagonize the alcohol, but we found it promoted a more confused state."

Research scientists of the Addiction Research Foundation consulted on this point say that the key phrase is "caffeine capsules containing the equivalent of *several* cups of coffee". The actual dose is very important, since a strong dose of such a stimulant as caffeine or amphetamine leads to increasing jitteriness, incoordination, and confusion. If this confusion effect is added to that produced by a prior dose of alcohol it could well make matters worse.

FOUNDATION NEWS . . .

• **I. P. McNabb,** a member of the first board of the Alcoholism Research Foundation of Ontario (as it was named then), appointed in May, 1949, retired as chairman of the Foundation in February of this year after serving for nearly 10 years as head of the policy-making board. (Mr. McNabb succeeded Mr. Justice Arthur Kelly, Q.C., as chairman in 1953.)

At a special Foundation meeting honoring Mr. McNabb and his successor as chairman, **S. R. Stevens,** the Hon. Matthew B. Dymond, M.D., Minister of Health for Ontario, paid tribute to the spirit of public service which moves busy, leading citizens of the province to give voluntarily of their time and energy to the work of the Foundation without any financial compensation. This, said Dr. Dymond, is "public service in the fullest sense of the words".

Mr. McNabb, who is continuing as honorary chairman of the Foundation, is an insurance executive. Mr. Stevens, now chairman and a member of the board since 1953, is area marketing manager for the Bell Telephone Company of Canada.

- **A conference on medical aspects of motor vehicle accidents** held in Ottawa in March under the sponsorship of the Royal College of Physicians and Surgeons of Canada invited a presentation from the Addiction Research Foundation on critical blood alcohol levels in drinking drivers. The conference was addressed by the Foundation's executive director, H. David Archibald.

- **Miss Joy Miles,** a former assistant supervisor of occupational therapy for the Ontario Hospital, Queen Street, Toronto, joined the Toronto clinic of the Addiction Research Foundation in February of this year to initiate an occupational therapy program. Immediately prior to joining the Foundation Miss Miles had been engaged in establishing such a program for the Juvenile and Family Court Clinic of Metropolitan Toronto.

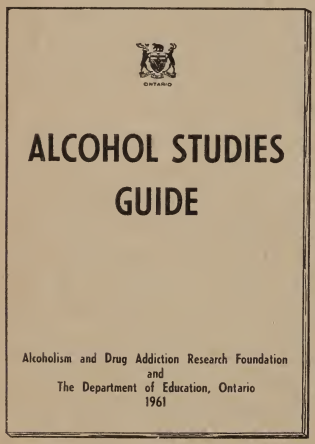
- **Dr. M. E. W. Gooderham,** a general physician in private practice in suburban Don Mills for several years, has joined the staff of the Foundation's Toronto clinic on a half-time basis.

- **The Canadian Council on Alcoholism** brief to the Royal Commission on Health Services was submitted on behalf of seven provincial alcoholism control organizations (all except New Brunswick, Newfoundland, and Prince Edward Island) at the Commission's Toronto hearing May 7. Representing the Council were the chairman and executive director of the Ontario Addiction Research Foundation, Messrs. S. R. Stevens and H. David Archibald.

"SKIP THE HEALTH LESSON, TEACHER!"

The following summary appears at the conclusion of an article entitled "Skip the Health Lesson, Teacher!" in the April 7, 1962 issue of The Canadian Medical Association Journal (pages 644-647). Its author is G. J. Millar, Ph.D., professor and acting head of the Department of Physiology and Pharmacology, University of Saskatchewan, Saskatoon:

"Since about 1875, teaching in Canadian schools as it pertains to health and hygiene has received no guidance, so far as this writer is aware, and no organized aid from scientists or the medical profession. The pitiable results of this neglect are evident on every page if one examines official educational publications and the textbooks that are used in this field. If biological scientists and physicians were to accept their responsibilities to the nation and to the subject matter of these courses and make an active effort to improve the latter, an element of sanity would be introduced that could affect the whole science program in our schools, and possibly the attitude of the public toward these professions."



Dr. Millar had not seen these two carefully authenticated Foundation publications for teacher and student.

Addictions

Volume 9, No. 1 Summer 1962

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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (365-4545)

There are also branch offices at:

155 James St. South, Hamilton (JA. 7-4941)

447 Waterloo St., London (GE. 3-3171)

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Addictions

SUMMER, 1962

ADDICTIONS occasionally receives letters which are worthy of publication, like the one on page 34 of this issue. About twice a year, on the average, we get another kind of letter — the kind that irately demands that we cease forthwith sending our "insulting" publication to a particular address.

When this non-fan letter arrives we immediately remove the offending address from our list and write a note to explain our purpose and policy.

It is definitely not the policy of the Foundation to send material about alcoholism or drug addiction to an individual unknown to us when requested to do so by another equally unknown individual. This kind of thing could result in quite justifiable kickbacks from suspected addicts whose well-meaning relatives are trying to get at them indirectly. We have always declined this third-party kind of request.

Occasionally, however, we do obtain the names of citizens who have attained positions of influence in their communities and whom we feel may therefore be able to further the enlightenment of many of their fellow citizens regarding matters alcoholic or otherwise addictive. Usually when we introduce such community, business, or professional leaders to our publication they express their appreciation. Once or twice a year isolated individuals take umbrage. To these rare writers of non-fan letters we apologize.

Various Methods Can Help the Alcoholic Once He Sincerely Wants to Help Himself

*By Hugo Solms, M.D.**

We can help the alcoholic, but we cannot do the whole job for him. We need his cooperation — he has to help himself. His motivation is very important. The alcoholic will not stop drinking until he reaches the point where the discomfort and suffering resulting from drinking exceed the sense of pleasure and relief it gives him. Therefore, therapeutic success does not only depend upon the gravity of his alcoholism, on its developmental stage, its environmental aspect and the treatment facilities available, but also it depends to a great extent upon the moment at which rehabilitation starts. Once the patient has become ready for it, almost anything will help. But this may take years; and one should not wait too long because once he has lost too much — his family, his job, his health — treatment becomes much more difficult or sometimes impossible.

As Early as Possible

Early detection and rehabilitation are therefore of prime importance. These can be facilitated both by the attitude of the general population toward alcoholism and by laws to provide compulsory treatment in certain cases. It is recognized, however, that young alcoholics, who have not gone through so many threatening and frustrating drinking experiences as older ones, are often rather defensive, minimizing or denying their abnormal behavior and blaming the environment. To obtain rehabilitation in some of these cases it may be necessary to induce a crisis.

The first interview with a patient is of great importance and its outcome can be decisive for the future evolution of his alcohol problem. Success depends not only on diagnostic insight, on understanding the patient, or on the choice of appropriate treatment procedures, but also on the therapist's personality make-up and his

* Dr. Solms is a psychiatrist with the Universitatspoliklinik, Berne, Switzerland, and a member of the Swiss National Committee on Mental Hygiene and of the Federal Commission on Alcoholism. He was a visiting research fellow with the Addiction Research Foundation in Toronto during 1961. This paper was given at the Third World Congress of Psychiatry in Montreal in June 1961. It is published here for the first time by special permission.

own attitude toward life. These are the elements in establishing a positive relationship with the patient; and this may be even more important than the treatment methods used. (Unfortunately it is often difficult to obtain the cooperation of the drinker's family in a non-condemning, tolerant, helpful attitude, especially that of the alcoholic's spouse. Not infrequently does the personality structure of the wife of an alcoholic favor alcohol abuse by the husband.)

Non-Drinking Group Support

Alcoholics need to be integrated into a non-drinking social milieu which will provide them with a strong supportive group ideal. Remaining sober and helping others to do so may become an essential life goal and a valuable substitute for social drinking customs. It is interesting to note that North American and Scandinavian alcoholics prefer an Alcoholics Anonymous type of group, whereas alcohol addicts from Central Europe seem to do better with a more authoritarian type of temperance society group setting.

The Patient and His "Field"

Complex dynamic factors, i.e. socioeconomic, occupational, cultural, spiritual, psychological and somatic disturbances or maladaptations are involved with chronic alcoholism. For this reason, a single standard treatment technique cannot be established. Therefore, the modern approach is through the integration of the pharmacological, psychotherapeutic, social care and group procedures, as well as the educational and legal facilities into a vast teamwork. It is a combined effort, directed not only toward the patient himself, but also toward his "field" (family area, occupational area, etc.). Sometimes the approach to the patient, sometimes that to his field will prevail.

Since in chronic alcoholism no specific and no standard treatment can be expected, one has to handle the patient's condition at least symptomatically on all the parameters or dynamic factors involved, i.e. on the socioeconomic as well as on the occupational, the psychodynamic and the physiopathological levels.

To establish the appropriate treatment and social care approach in a given case, the following should be considered:

a) the type of chronic alcoholic syndrome (problem drinking, inveterate alcoholism, psychological or physical dependence, etc.

b) the developmental stage of the chronic alcoholic syndrome;

c) the relative importance of the dynamic factors implied.

Table 1 describes the importance of the main dynamic factors involved in the most common syndromes of chronic alcoholism. It will be understood, that when isolating different syndromes of chronic alcoholism, a certain schematization cannot be avoided. On the other hand, the alcoholism syndromes, described in Table 1, can also be developmental stages. This is true in cases characterized by a progressive nature of their alcoholism.

Table 2 gives a schematic survey of the main points of impact of various treatment and social procedures and what their indications are.

Directives can be derived and made available in the choice of treatment through an integration of the topics of these two tables. But they do not suffice, since the treatment of choice in any individual case depends also on the patient's motivation, on his social environment, and last but not least, on the available therapeutic, social care and community facilities.

Abstinence Is First Step

Addictive drinking must be brought under control and complete abstinence must be achieved, before any deeper therapeutic effort follows. In most cases, immediate and abrupt withdrawal is advisable and also possible. In severely intoxicated cases of chronic inveterate alcoholism, as found frequently in wine-growing areas (France, Rhineland, southern Switzerland, etc.) a method of slow withdrawal in the form of intravenous injections of Curethyle (25% alcohol, glucose and liver extract) has been widely accepted, though without real evidence of its advantage over other withdrawal procedures. The usual detoxification methods tend to correct somatic exhaustion, metabolic disturbances and nutritional deficiencies. A clear understanding, however, of what is designated by the widely accepted term detoxification has not been reached yet. But the toxic factor (i.e. direct or indirect alcohol-toxic effects) plays an important role in the acute phases of chronic alcoholism. Withdrawal symptoms can arise if the treatment approach is not appropriate. In this paper, however, the handling of acute alcoholism will not be dealt with.

chronic alcoholism (schema modified after E. M. Jellinek and P. Fouquet).

main dynamic factors involved in chronic alcoholism		customary *social drinking* with regular abuse and resultant damages	*undisciplined problem drinking* with resultant disturbances	severe chronic alcoholism with *loss of control* (pseudoperiodic alcoholism)	severe chronic alcoholism with *inability to abstain* (excessive daily consumption)
sociocultural and economic factor		***	*	*	****
psychodynamic factor		*	****	****	*
physiological vulnerability		?	?	?	?
tolerance factor: acquired increased tissue tolerance (later on: decrease in tolerance)		*	*	***	****
main addictive features:	loss of control	0	0	****	possibly as a very late development
	inability to abstain	0	0	0	****
toxic factor: acute alcohol-toxic disturbances necessitating detoxification		*	(*)	**	****
progressive alteration of the psychosocial behavior pattern induced by alcoholism		(*)	(*)	****	***

Table 2: Points of impact of social care and therapeutic measures on some dynamic factors involved in chronic alcoholism.

Social Care and Therapeutic Measures:	Points of Impact:
Prevention through education, legislation, amelioration of standards of living, temperance societies (European type).	Sociocultural and economic factors.
Social care: case and group work; recreational activities; team approach involving the drinker's family, the employer, the A.A., the temperance organizations, the probation officers, the service professions in the community.	The alcoholic's "field" (his environmental situation).
Psychotherapy: individual: counselling, supportive, directive/non-directive, analytically oriented, hypnotic, relaxing, group psychotherapies.	The alcoholic's psychodynamic factors (psychological vulnerability, progressive alteration of his psychosocial behavior pattern induced by chronic alcoholic deterioration).
Disulfiram: (Citrated calcium carbimide acting similarily, but far weaker.)	Protection against loss of control when starting drinking, or against relapsing when abstaining, through *sensitization to alcohol,* involving various psychodynamic mechanisms (c.f. strengthening helpful defense mechanisms, etc.)
Apomorphine:	a) *if emetic doses are given in a group treatment setting,* they foster psychocathartic abreactions, weaken rigid defense mechanisms, facilitate acceptance of failing in life and open the door for psychotherapeutic and social care interventions; they protect the patient temporarily against loss of control when starting drinking or against relapsing when ab-

	staining through provocation of reactions of disgust or conditioned nausea responses. b) *if subemetic doses are given,* they have sedating and "detoxifying" properties and facilitate relief from withdrawal symptoms.
Emetine:	*If, as usual, emetic doses are given,* Emetine protects the patient temporarily against loss of control when starting drinking or against relapses when abstaining, through provocation of reactions of disgust or of conditioned nausea responses.
Major and minor tranquillizers:	Sedative action. Facilitating psychotherapeutic and social care interventions, as well as relief from withdrawal discomfort.
Central stimulants and antidepressive drugs:	Partial relief from minor abstinence symptoms, especially when associated with dysphoria, exhaustion or mild depressive features.
Hormones (especially Insulin, adrenal steriods, etc.):	Helpful in fighting intoxication and withdrawal symptoms as well as physical exhaustion in acute alcoholism.
Vitamins and liquid support, liver protecting and dietary measures:	Helpful in "detoxification" and replenishment of food and minerals, as well as correction of the disturbed mineral and liquid balance (in acute alcoholism and in chronic forms with nutritional deficiency).
Alcohol given intravenously:	In the form of *Curethyle* (25% alcohol, glucose, liver extract) used in some European viticultural areas as a method of slow alcohol withdrawal to avoid abstinence symptoms in special types of acute alcoholism — Moreover, alcohol i.v. is sometimes used in brief psychotherapy as an activator of repressed dynamic material.

After Detoxification

Only after detoxification has been achieved, can the basic emotional and social pathology be taken care of: character disorder; neurotic or psychotic conflict pattern; marital difficulties (with special emphasis on the alcoholic's spouse), distorted interpersonal relationship pattern; religious problems and social guilt feelings (depending to a great extent on the attitude of the patient's environment); occupational difficulties, etc.

There is little agreement on the kind of *psychotherapeutic approach* which would be most effective. As a matter of fact, there is as yet not sufficient understanding of the therapeutic possibilities inherent in the various forms of individual or group psychotherapy (analytically oriented, directive or non-directive, hypnosis, relaxation, etc.) for the alcoholic. In practice in the present situation, one's choice of a psychotherapeutic approach depends much more on the existing treatment facilities, the philosophy of the setting and the personal skill of the therapist, than on the type of patient and his specific "field". The treatment staff dealing with alcoholics must be ready to handle a lot of frustrating hostility, overaggressiveness, exaggerated dependency needs and to accept the inevitable relapses. A good therapeutic community may therefore be of tremendous support to the treatment staff as well as to the patient.

There is, however, some agreement, that in the majority of cases an *analytically oriented supportive type of brief psychotherapy* is sufficient. Many other alcoholic patients can be handled by the social worker alone, without involving a psychiatrist, through *non-directive counselling, advice or guidance.*

Seldom for Psychoanalysis

There has been a great deal of argument over the years as to whether *psychoanalytic treatment* was necessary in drinkers with severe emotional disturbances and personality disorders. However, experience has shown, that in the majority of alcoholics, psychoanalytic therapy is not indicated. The reason for this is not just because it is expensive and requires a lengthy period of time, as well as a certain educational background and intellectual capacity, but also and more significantly because alcoholics, as well as other drug addicts, have a remarkably decreased level of stress tolerance, and therefore cannot stand the frustrations inherent in any stan-

dard psychoanalytic approach. In the psychoanalytic treatment situation, these patients would not be able to sustain the continued urge to act out in the form of drinking. It can often be observed, that the central pathological symptom, the addictive drinking, then becomes the principal resistance preventing any progress of the transferential dynamics. Moreover, many alcohol addicts are too deeply regressed to oral-infantile needs for dependency and protection, and do not have sufficient super-ego structure. On the other hand, the addictive behavior in itself is often so gratifying to the patient, that his motivation for recovery is too weak. The therapist handling alcohol addicts must therefore play a more active and gratifying part than the analyst. Moreover, further support in the field of the patient's environment, i.e. the cooperation of social workers, employers, and family, and sometimes the prohibitive action of sensitizing or repelling drugs, is necessarily a part of the treatment approach.

Psychoanalytic therapy, or at least a psychoanalytically oriented intensive long-term individual psychotherapy is indicated only in the very rare cases where a well structured neurosis with highly frustrating inner conflicts and interpersonal difficulties forms the basis of the problem drinking, and where the patient displays strong motivation for recovery.

Hypnosis Helps Some

Hypnosis can be of some help in the rare cases of motivated patients with good insight into their weaknesses and with a passive dependent type of personality, if their psychological conflicts lead to a sort of tension which can be temporarily lightened by cathartic abreactions. Mostly, hypnosis has been deceptive with alcoholic patients. Easily hypnotizable drinkers are natural preys to any kind of social pressure, (the widely accepted drinking customs).

"Autogenic training," an autoconcentrative relaxation method of I. H. Schultz, may again in some highly motivated alcoholics with a differentiated personality make-up, reduce tension and anxiety, and they may consequently be better equipped to cope with their lowered level of stress tolerance.

Group Psychotherapy

The psychotherapeutic group work helps the rejected patient to come out of his isolation. Its permissive atmosphere can reduce tension, anxiety and guilt feelings. Moreover, the dynamics of the group psychotherapy situation facilitate cathartic and abreactive processes. Since many alcoholics display intense needs for dependency, they often can cope more readily with the multiple transferential situation in a group setting, than in the doctor-patient "à deux" relationship such as exists in individual psychotherapy.

The psychotherapeutic effort can sometimes be facilitated by cathartic procedures such as Pentothal subnarcosis, by abreaction through intravenous amphetamine shocks, or by pharmacoanalytic methods using psychotomimetic drugs such as LSD, mescaline or psilocybine.

Drug Treatment Aids

The two main drug therapy approaches to addictive behavior in alcoholics (sensitization to alcohol through disulfiram and aversion treatment with apomorphine or emetine) act merely as adjuncts to the psycho- and sociotherapy. They help erect an initial protective barrier against the danger of relapse, which is especially high in the first six to 12 months, and thereby make the handling of the conflict problems and of abstinence easier. The fact should not be overlooked, that not only complex physiodynamic, but also and more significantly psychodynamic action mechanisms are involved in these drug treatment aids. However, this aspect cannot be dealt with in this survey.

The method of administering disulfiram varies according to the many therapeutic approaches and policies of different treatment centers. Some therapists let the patient himself take the tablets in a highly permissive way, others — mostly in Europe — administer antabuse only under strict supervision of volunteers, social workers or responsible friends of the alcoholic, so that the patient never handles the drug himself. Often, consideration is not given to these important differences in follow-up studies establishing the value of this protective drug treatment aid. After more than a decade of world-wide experience with disulfiram it has been proved, that this drug is most valuable with a group of alcoholics showing poor motivation and a passive dependent personality type, provided that

some compulsory treatment facilities are also available. Well motivated voluntary patients generally do not require such a pharmacological aid: disulfiram with these patients, if taking the drug themselves, has no protective function, but acts merely as an indicator of their motivation and cooperation, i.e. as a "prognostic criterion."

Since the reaction to alcohol in subjects sensitized by citrated calcium carbimide (Temposil) is not strong enough, this drug has not been widely accepted in spite of its lower toxicity. However, with disulfiram there is no risk of complication involved, if the few contra-indications are taken into consideration. The same is true for apomorphine and emetine.

Authoritarian Implication

One of the reasons that the latter drug treatment aids are not so well accepted as antabuse, especially on the North American continent, may be that their application implies a certain authoritarian aspect which is more common in European countries with compulsory treatment facilities. As far as the apomorphine treatment is concerned, it is more suitable for severely intoxicated inveterate alcoholics with inability to abstain (in wine-growing areas) than to the problem drinker type with loss of control, more common in North America..

Minor Withdrawal Symptoms

It is not uncommon that a patient who gave up drinking for the first time, will for weeks go through minor withdrawal symptoms characterized by tension, headache, general discomfort, restlessness, anxiety, increased hostility, sleep disturbances, tremor, etc., a two-fold condition with psychodynamic as well as physiopathological factors involved. In these cases, various minor tranquillizers (such as meprobamate and librium), as well as neuroleptic and sedating drugs are helpful. But the main problem remains the handling of the psychodynamic situation. If dysphoric, asthenic or depressive features are involved, a low dosage of amphetamines or a mildly acting monoamino-oxydase inhibitor can help the patient.

Some hypotheses relating addictive behavior to physiological or constitutional aberrations have led to special treatment recommendations (high vitamin supply, adrenocortical hormones, triiodothyronine, l-glutamine), but without notable success. ■

Summer Course on Alcohol Problems

Teachers' seminar

Clergy Seminar

Nurses' Seminar

Canada's first solidly professional course on alcohol problems was convened on the University of Toronto campus June 18. Jointly sponsored by the U. of T. Division of Extension and the Alcoholism & Drug Addiction Research Foundation, it occupied 58 registered participants morning, noon, and night for two full weeks.

Aiming at graduate level understanding, the 21 50-minute lectures, four panel discussions, six afternoon seminars, A.A. meeting, and tours of alcoholic rehabilitation centres covered most aspects of this multifaceted problem. Necessarily all aspects could not be probed exhaustively, but the aim was to cut across professional boundaries and give each a broader view.

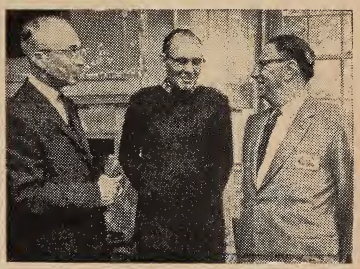
The majority of participants came from various parts of Ontario, but some came from as far afield as Alberta, Manitoba, Quebec, Newfoundland, New Jersey, and Louisiana. They represented nursing, social work, psychology, psychiatry, industrial medicine, teaching, clergy, and law.

A departure in programming that attracted much favorable comment was the question-sharpening period following each lecture. These were small discussion groups comprising men and women from different professions, and their purpose was to focus attention on points raised in the preceding lecture which required expansion or clarification. Each lecturer was then put on the spot for an additional 30 minutes to discuss these questions.

Heading up the 28-member faculty were Dr. E. M. Jellinek from Stanford University, California; Dr. Erik Jacobsen from Copenhagen, Denmark; and Fr. John C. Ford, S.J., Catholic University of America, Washington, D.C.

Fr. Riffel, Toronto; Fr. Lawrence, Stirling, N.J.; Miss Faulkner, New Orleans.

Mr. Goddard, Toronto; Brig. Monk, Harbor Light, Toronto; Mr. Woodland, Newfoundland.



Some Drugs and Their Effects Reviewed and Reasons for Addiction Considered

*By Erik Jacobsen, Ph.D., M.D.**

Apart from purgatives, there are five reasons which may cause normal persons to take drugs — (i) The drugs may combat fatigue, (ii) they may improve the mood, (iii) they may let us forget our worries, (iv) they may bring sleep, and (v) they may bring dreams.

Combatting Fatigue

In spite of the natural laziness of the human race, there may be situations where we want to be awake and alert. The story tells that tea was invented by a Buddhistic monk who had difficulties in keeping himself awake during the night's meditations. Today's student has had the same experience with coffee. The Peruvian Indians chew coca leaves in order to endure hunger and fatigue, and soldiers in the battle may be given amphetamine.

Improving One's Mood

Some drugs are able to improve the mood. If we are not depressed, have no nausea, no head-, tooth- or other ache we are not aware of our mood and, moreover, we do not care. But under the influence of certain drugs we may suddenly be conscious of a wellbeing, a feeling which may be so intense that it is as if every cell in the body is informing the central nervous system that everything is well and has never been so well before. This feeling is called euphoria, a Greek word composed of "eu" = "good", "well", and "phero" = "I bear", that is literally "well-being".

In medical usage "euphoria" means an unnatural feeling of wellbeing beyond what is justified by the situation. We talk about euphoria when a deadly ill patient declares that he is feeling well, and also when a normal person realizes his wellbeing. The feeling of euphoria is naturally varying, and ranges from the point where a person after a small dose of alcohol just appreciates that he is

* Dr. Jacobsen, co-discoverer of Antabuse, is medical director of the Medicinalco Research Laboratory, Copenhagen, Denmark. This is part of a lecture he delivered in June at the Addiction Research Foundation's first summer course on alcohol problems.

feeling well to the almost orgasm-like feeling described by morphinists taking morphine intravenously. Characteristic of the euphoric is that symptoms which under other circumstances would be very distressing are of little importance. The nausea which frequently accompanies morphine intake is unimportant to the morphinist.

Not a few drugs are able to induce euphoria; meprobamate, alcohol, amphetamine, morphine and cocaine, mentioned approximately in the order of increasing activity, but the effect varies from individual to individual and with the way of administration.

To Erase One's Worries

It is well known that life is filled with worries. Some have a real background — the international situation, troubles in the family, or worries over the outcome of a serious disease. In other cases the causes for the worry are more imaginary, ranging from a slight feeling of mental insufficiency to the raging, paranoid and tragic jealousy of Shakespeare's Othello. Drugs having a calming influence on worries, true or imaginary, are called tranquillizers.

A suitable tranquillizing drug may make a patient with an advanced cancer be just as indifferent to his disease as if it were a complete stranger who suffered from it. No wonder then that worries without a real background also may be erased by the same kind of drug.

Although it is only ten years ago since the word "tranquillizer" was coined, the effect has been known for a much longer time. Alcohol has been taken for centuries in cases of stress. And more recently some of the barbiturates and especially meprobamate have produced a similar action. Undoubtedly much of the analgesic effect of morphine is due to its tranquillizing property. Many patients with severe pains state that the pains are still there after the morphine has been given, but their disturbing influence and the accompanying anxiety have disappeared.

Sleep-Inducing Drugs

The sleep-inducing effect is intimately linked to the tranquillizing effect. Worries and anxiety have a tendency to peep out when a man is left alone and is trying to sleep. Not only worries and anxiety may prevent the sleep, but in many instances the mere thoughts that the work the following day is hampered by lack of

sleep may keep the patient awake. A drug which is able to bring the person out of a vicious circle of this kind is more than welcome. The wish to have a refreshing sleep and to wake up in the morning fit to face new troubles fully explains the increasing demand for hypnotics in modern life.

Makers of Dreams

Dreams are not only found during sleep. They may also appear when a person is half awake, and even when he is in a state of full consciousness. Dreams may be defined as a more or less pronounced materialization of the thoughts. When this materialization is felt so vividly that we forget that they are fostered by our own brain, we speak about hallucinations. In this way a sliding scale is found reaching from pure thoughts to ideas falsely interpreted as realities. All steps on this scale may be provoked by drugs.

The meditations over a pipe of good tobacco may hardly be called dreams, but morphine gives intense day-dreams. True hallucinations, however, appear after the intake of other drugs, among which may be mentioned alkaloids isolated from Central American drugs, known and used by the Indians long before Columbus. Here are mescaline from cactus buds and psilocybin from certain kinds of mushrooms. Modern chemistry has also here made compounds with exactly the same effects. Many names have been coined for these substances: Hallucinogens, phantastica, psychosogens, etc.

Related to this group, but with a different effect on some points are the effective substances in marihuana. This drug is also able to give hallucinations, but besides it releases a mental and physical energy which may be desirable in some situations helping to perform music or dance.

Undesired Side-Effects

Some of the drugs mentioned here are regarded as dangerous to such an extent that every possible measure is taken to prevent their use for non-medical purposes. One reason for this is that the drugs in addition to their wanted properties may produce side-effects which are dangerous for the individual or for society. We find side-effects which appear already after a single dose, especially if it is too large or taken by an unaccustomed individual. Some types of acute side-effects are only disagreeable. Nausea and vomiting, such as found after morphine, or hang-over felt after

alcohol are purely private affairs of the consumer, but when the side-effects interfere with bodily or mental functions in such a way that this may endanger other people it is a different matter.

The muscular ataxia and the mental indifference found in individuals with a certain alcohol concentration in the blood make them completely unfit to handle every type of machinery, moving or stationary, on the ground, at sea and in the air. Other drugs, especially the sedatives and the tranquillizers may have a similar effect. Another example of an effect which may cause trouble for the individual or for society is the violent aggressiveness sometimes found after the consumption of marihuana.

Long-Term Side-Effects

The second type of side-effects are those which appear after chronic use and which may attack the mental and physical health of the consumer. The well-known symptoms of chronic alcoholism offer a typical example of the result of chronic and repeated use of a drug. The symptoms of the chronic morphinism and cocainism will be mentioned later.

Almost every drug, if used for a sufficiently long time in sufficiently large doses will cause symptoms, characteristic for this particular drug and different from that seen after other drugs. Most symptoms will appear in all patients if they take doses large enough and continue their consumption for a sufficiently long time. However, we also know of symptoms which will appear only in a certain number of consumers, relatively independently of dosage and time. It is presumably generally acknowledged that heavy cigarette smoking may provoke lung cancer, but it seems as if not every cigarette smoker will be attacked. Apparently he only increases his odds for getting lung cancer from about 1:10,000 to about 1:300.

Tend Toward Loss of Control

The main problem with most of these drugs is, however, that they may tempt people who once have started to take them to continue, to increase their consumption and finally to be unable to stop or even control their consumption. The addiction induced in this way assures that the side-effects from chronic intake cannot be avoided, and the following mental and physical deterioration

offers further reason for society to attempt to prevent any consumption not medically indicated.

Factors Leading to Addiction

At least three factors lead to addiction with all its consequences, one is psychic and the two others are pharmacological.

An essential part of the psychic factor is that the consumer likes the effect of the drug. It is not necessary that the first experience is a hundred percent pleasure. The first cigarette or the first drink are rarely a real pleasure. Most people get nausea and vomiting from the first dose of morphine. But if there has been at least some agreeable element in the effect, the temptation for a second try is obvious.

In order to induce addiction, the drug must appeal to the consumer in one way or another. It may either induce euphoria, erase his worries or give him something he misses. He may, for example, lack the ability to make contact with his fellow men. Here, he can either take to agents like alcohol which facilitate the group feeling and make him feel as a part of a happy brotherhood. Or he can take an agent the effect of which is to replace the group feeling such as morphine. Some people want new and exciting experiences in the form of dreams or fantasies able to carry them from this dull and troublesome world.

From Habit to Dependence

Once started, the use of a drug may become a habit, and once a habit, a psychic dependence is developed. This psychic dependence is presumably connected with conditioned reflexes; especially in the cases in which the drug consumption is linked to certain situations. Some persons are dying for a cigarette between the courses of a banquet, others must have a drink at certain hours of the day, etc. This type of dependence is not confined only to drugs but is found in many other human activities. Man has an inclination to exaggerate and sometimes follow a certain line beyond all sense; gambling, avarice, eating, sexual activities, hunting, and art-collecting are some examples of such activities not induced by drugs. They may not only increase to vices, but they may have social consequences and even lead to violation of civil or criminal laws. This is well known, and, therefore it is no wonder that the

use of drugs with pleasant effects may increase to a point which seriously influences the victim's life. At this point or even before the pharmacological effects begin to play a role for the development of addiction.

Drug Tolerance

If a drug is given repeatedly at relatively short intervals, e.g. daily or at least every few days, the effect may decrease, and the doses have to be increased in order to maintain the effect. This phenomenon is called drug tolerance. After a certain pause in the administration, varying from drug to drug, the former reactivity is regained.

Tolerance occurs with a large number of drugs, and is well-known by pharmacologists and clinicians. Tolerance is found not only in drugs acting on the central nervous system, it may also be seen with drugs having a purely peripheral effect. Nitroglycerol may lose its effect in heart angina after prolonged use, and it may be necessary to discontinue its use for some days in order to restore its former effect. However, drugs having an effect on the central nervous system are the most liable to develop to tolerance. The ease with which tolerance is developed and the degree it can attain varies much from drug to drug. Tolerance to the hypnotic effect of, for example, chloral-hydrate requires a much more prolonged use than does the hallucinogenic effect of LSD. The second dose of the latter drug is almost eliminated if it is given within 24-48 hours after the first. The other extreme is cocaine which according to the literature gives a low tolerance.

One's Drug Another's Poison

The degree to which the tolerance maximally can be developed varies very much from drug to drug. It is hardly known how much the concentration of a gas narcotic necessary to give narcosis must be increased by repeated administration, but it is presumably less than 25 per cent. In contrast to this the tolerance to morphine is able to reach such a degree that the daily dose of a morphinist may be several times the lethal dose for individuals not accustomed to morphine. The degree of tolerance obtainable with other drugs is placed between these two end points. The tolerance does not only vary from drug to drug, but also within the different effects of the

same drug. While the tolerance of the central nervous system towards morphine as mentioned may be extremely high, the tolerance towards the effect on the intestines, manifested by the constipation after morphine, is little pronounced. Such a variation of tolerance from symptom to symptom is found with almost every drug.

It is a general rule, although not without exceptions, that the central effects, especially the most desirable, such as euphoria or analgesia, are the most liable to tolerance, while the peripheral effects, such as constipation, increase of blood pressure and even headache, etc., are less liable. For this reason, the continued use of a drug may be less and less agreeable.

Tolerance Not Understood

The physiological mechanism behind the development of tolerance is still not cleared up. It is not due to the fact that the organism has developed a change of its metabolic processes causing the drug to be eliminated at a higher rate than before. The tolerance is an expression of a true increase of the susceptibility of the body towards the drug. The tolerance seems to be rather specific.

An alcoholic cannot take a larger dose of morphine than can a normal person. On the other hand drugs acting the same functions within the central nervous system show *cross tolerance*. This means that an organism which has developed tolerance to one drug also shows tolerance to all other members of the same group. A man who has acquired tolerance to morphine will also show tolerance to methadone, even if he has never tasted this substance before in his life. The phenomenon of cross tolerance plays an important role in the testing of a new drug for morphine-like effects.

Two Possible Explanations

The tolerance found in the higher mental functions may be explained in two ways. One is that new pathways in the central nervous system are opened, leading around the centers which are totally or partly blocked by the drugs. More popularly said this means that the individual consciously or unconsciously has learned to eliminate the effect of the drug. For a long time it was thus claimed that tolerance to alcohol was caused by the fact that the

individual had learned to "carry his drunkenness with dignity". It is possible that this mechanism plays some role, but it is far from being the most important factor. Most probably the principal effect is found in a change in the biochemistry of each single cell.

There is a phenomenon in physiology called *homoistasis*. The body temperature is homoistatically regulated, and so is the composition of the blood together with thousands of other factors important for the organism. Homoistasis is a Greek word; derived from *hómoios:* like, similar; and *stásis:* stand still, i.e. keeping the level. The body makes all efforts to maintain an optimal or at least a suitable level for its function. If some force is trying to disturb the equilibrium, a long series of counter-regulating functions are automatically working to re-establish the optimal level. This happens not only in the whole body but also within each single cell. If the metabolic equilibrium in this cell is disturbed, *incasu* by a drug, the proportion between the enzymes may be altered so that the disturbing influence is more or less eliminated. From this follows that increasing doses are necessary in order to exert an effect. This point of view is so far hypothetical but seems probable, especially because it is also able to explain the abstinence symptoms.

The Abstinence Symptoms

If an individual has used a drug in increasing doses for a long time and the administration of this drug is discontinued abruptly, abstinence symptoms may appear.

Such symptoms are of true somatic origin. They are not only psychic. It is true that psychic abstinence symptoms may be found. In their severest form, for example the grief after loss of a strong emotional contact, they may even give somatic symptoms such as loss of appetite, precardial pains, palpitation, etc. But the abstinence symptoms discussed here are of a different origin. They are purely pharmacologically induced.

The nature of these symptoms varies from drug to drug. With morphine they are very violent, especially the vegetative regulation is disturbed, giving cardio-vascular disturbances with a fall in the blood pressure, cardiac symptoms, etc. These symptoms are combined with an extreme feeling of discomfort, much dreaded by the morphinists under treatment. And with some reason, the morphine abstinence symptoms may cause collapse, even death.

After the sedatives a different type of abstinence symptoms is seen; here the susceptibility of the nerve cells in the brain is extremely increased, so that the abrupt discontinuation of the drug may release convulsions. This is found after the barbiturates, meprobamate, chlordiazepoxide and alcohol. A possible explanation of this hypersensitivity of the nervous system is that the increased susceptibility of the cells suddenly is manifested when the cells no longer are exposed to the drug.

Not all drugs cause abstinence symptoms to the same degree. As a general rule, it seems as if drugs with a sedative effect such as morphine, barbiturates and meprobamate show a higher tendency to cause abstinence symptoms than do the stimulating drugs, such as cocaine and amphetamine. In the treatment of addiction the dosage of the drugs which cause abstinence symptoms must be gradually decreased while drugs which give no abstinence may be discontinued from one day to another.

Characterization of Drugs

The drugs are characterized by a number of parameters the combination of which determines the extent of use, misuse and potential danger of a certain drug and with this the attitude of society or the individual toward this particular drug.

In the first place is the appeal of the drug to the individual. Some drugs only appeal to the few, e.g. phenacetine or antipyrine, others such as alcohol, tobacco and coffee appeal to the many. The appeal varies with many factors, some of which seem quite irrelevant. There are racial differences. Opium smoking, so popular in the Far East is extremely little used in the near East or among Europeans. Even within the same race the appeal may vary from place to place, from social layer to social layer, and from time to time. There seem to be fashions in the use of drugs just as in many other forms of human behavior, and when a thing is going to be fashionable, its use may spread as a prairie fire, both across whole continents and in small groups.

Drug Use Contagious

In this way the use of drugs may be extremely contagious. But not only that, misusers of a drug even seem to work actively for its propagation. Doctors who are morphinists thus prescribe morphine very liberally and may thus help to create new addicts. In certain

social circles, if a man has started to use a new drug and finds its effect exciting, he will do his uttermost to persuade the other members of the group to try.

The intensity of appeal does not always follow the popularity of appeal. It is sometimes seen that some drugs exert a very strong appeal to relatively few. Even if cocaine were freely available in the Western countries I should guess that only five or perhaps 10 per cent would find it so pleasant that they would take it continually. But the few who would use it would become a very serious problem to society.

Euphoria and tranquillization are factors greatly influencing the appeal. The more intense these effects are the stronger the appeal. Combined, their effect on the appeal is still greater, such as found with alcohol, morphine, and perhaps also with meprobamate.

An easily developed *tolerance* may influence the tendency to addiction in different ways. A too rapidly developed tolerance may prevent an addiction. It is beyond doubt that one of the main causes that the hallucinogens are so little addiction-provoking is the fact that they seem to have lost most of their agreeable effect already at the second dose if it is taken too shortly after the first. This is, however, an exception; generally, a rapidly induced tolerance leads the consumer to increase the dosage and thus causes a more rapid development of the chronic physical and mental illness which may follow the abuse of the drug.

Fear of Abstinence

The development of *abstinence symptoms* is the fourth factor which must be looked at when the potential danger of a drug is considered. Obviously the phenomenon of abstinence plays a great role in the development of drug addiction. It may be difficult enough to stop the intake of a drug which has become a habit, but when it is combined with true physical discomfort, the effort to stop the drug intake is made a hundred-fold more difficult, not only for the patient himself, but the doctor who is going to treat him often also faces a difficult task.

Undesired Effects

The last factor here is called the *undesired effects*. There are two types of such effects. Some drugs may induce the consumer to

behave anti-socially. Some examples have been mentioned: The muscular ataxia which makes driving in a drunken state so dangerous, the extreme and uncontrolled violence which may be seen after marihuana, and the paranoic madness of the cocainist. It is natural that society's appraisal of a drug very much depends on its ability to induce this type of side-effect.

The other type of undesired effects concerns the individual's personal health. It is well-known that the chronic use of many drugs may cause a physical and mental deterioration which leads to invalidism. Especially in states with a well developed system of social welfare, steps must be taken against such drugs in order to prevent a need for the community to support a number of self-caused invalids and their families economically. ■

A Critical Look at Alcoholism Therapy as Undertaken in the State of Virginia

*By Ebbe Curtis Hoff, Ph.D., M.D.**

A valid research objective is to test the hypothesis that alcoholics comprise a mixed group of ill people suffering from a complex of psychological, social, spiritual and metabolic disturbances or maladaptations and who exhibit in common the symptoms of pathological use of alcohol. These symptoms include some degree of loss of control of drinking, harm associated with drinking, and need for alcohol to resolve problems or deal with psychological defects. Such research has value in permitting a categorization of alcoholic patients according to the relative prominence of the several underlying disturbances in each individual case and in providing data for exploring in depth the etiological factors which underlie them.

It appears likely that a constellation of etiological components will be found operative in varying degrees of significance. For this

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reason, research into therapies should include energetic emphasis upon a total approach to the patient and his family in a community setting. It may well be, however, that therapeutic investigation will bring to light an overriding single treatment modality (conceivably in the field of psychopharmacology) which, while not based upon a broad insight into etiology, may render the patient accessible to recovery processes not fully understood. It is recommended that therapeutic research on alcoholism include soundly designed studies of many treatment approaches in several therapeutic settings for patients with various diagnoses and social and other backgrounds.

Critical Points for Study

Evaluation of results of treatment of alcoholics requires continuing research into the description and diagnoses of patients, criteria of recovery and reliability of prognosis. In the Division of Alcohol Studies and Rehabilitation of the Commonwealth of Virginia, a broad spectrum of alcoholic patients is being studied under a limited variety of treatment situations. Special attention is given to investigation of patients capable of accepting therapy on a so-called voluntary basis. For such individuals, therapeutic planning is possible in a setting that provides for relatively short-term hospital care succeeded by prolonged treatment in an outpatient clinic in the patient's own community. A comprehensive diagnostic and therapeutic program is available through teams which include the psychiatrist, psychologist, internist, social worker, general practitioner and nurse. With these teams are associated basic research groups made up of physiologists, pharmacologists, and biochemists. These research groups are exploring metabolic and other parameters which may be significant in diagnosis and therapy.

The Usual Procedure

Patients usually contact the Division through their family physician, a family member, friend, AA member, clergyman, or a worker in some community agency. Contact is ordinarily first made with one of the nine outpatient clinics distributed throughout the state. For many patients therapy is limited to the outpatient clinic but usually the clinic physician admits the patient to the Division's specialized service in the Medical College of Virginia, Richmond, or to the medical or psychiatric services of the University of Virginia Hospital, Charlottesville. During the inpatient phase,

diagnostic studies are carried out, and plans made for continuation of therapy in the outpatient clinic nearest the patient's home. With the patient's cooperation, members of the family, the employer, clergyman, or other significant persons are drawn into the situation. Therapy in this initial period includes work in groups, presentation of didactic material in films, individual interviews with staff members and where necessary, job rehabilitation.

A large proportion of alcoholics can be treated by this approach. In the Virginia program over 50 per cent of the patients are admitted alcohol-free on admission while others are in a state of intoxication or alcohol withdrawal. Relatively few patients are deeply alcoholized and the number of patients with delirium tremens, hallucinosis, convulsions or other serious, acute manifestations is relatively small. A growing number of patients present themselves not for acute alcoholic emergencies but because of felt symptoms of anxiety, tension, nervousness, depression or panic. At the time of the referral interview and early in inpatient therapy, efforts are directed toward helping the patient to recognize and accept as far as possible the realities of his problems and to accept the need for continuing long-term therapy. While abstinence is held out as a necessity, it is made clear that this is a sign or manifestation of recovery which basically involves the process of becoming the kind of person who can live an alcohol-free life that is satisfying and productive. Far from marking the end of therapeutic needs sobriety signals the beginning of a new approach to life.

Categories of Patients

The patients of our Division fall into a variety of categories based upon major symptomotology. Many are dependent, frightened, lonely and impulsive with an apparently insatiable need for love, protection and reassurance that someone will care. Others are self-entrenched and are prone to withdraw. Still others are detached and seem to have given up, while yet others appear to be driven by needs for power and depend on proof of their own strength. A prominent category of neurotic patients with anxiety, phobic reactions, obsessive-compulsive behavior, depression and conversion symptoms may be delimited. Another group comprises those with prominent psychophysiological symptoms. Psychotic

patients constitute a much smaller number but patients with brain damage do form a significant though small minority.

Feelings in Common

Nearly all patients exhibit feelings of guilt, hopelessness, and worthlessness. There appears to be a need to apprehend their alcoholism as a result of their own indulgence for which they are now being justly punished. Some patients indeed feel that unless they regard their alcoholism as self-induced and due to their own fault, they will not be able to find the necessary solution. Alcoholics in our experience therefore tend to accept a common public stereotype that alcoholic behavior is a form of gross self-pampering and a bad habit which could be prevented by will-power and corrected by intensive self-discipline. This tends to block or delay the experience of surrender that would permit the patient to admit his own powerlessness over alcohol and the unmanageability of his life. A major early purpose of therapy, thus, is to help the patient face this powerlessness — this "hitting bottom". The extensive process of recovery does not really begin until he sees his condition as desperate and not amenable to trivial measures but requiring a drastic and thorough-going change of life. This surrender experience leaves the patient vulnerable to a profound insight into his own plight but it also opens the way — probably the only way — to a practical plan of recovery. Now, he is free to see himself at his worst, accept the necessity for powerful and continuing help from others. He can better explore and understand his need to drink and test the conclusion that alcohol cannot supply adequate answers to his straits. He no longer has to do violence to truth by saying he does not want to drink and promising he will never take another drink. Now, he can say "I would like to drink; I wish I could, but I have discovered I can't and must learn to face a life of sobriety."

A "False Cure" Trap

At this point, he must be helped to recognize the weakness of the formula: "Everything will be all right if I stay sober. My trouble is all due to drinking. I have promised never to drink again. I feel I shall never want a drink again so I have no problems." This kind of "false cure" awaits as a trap for the unwary patient,

especially after about a week in the protected environment of the hospital ward in which he has weathered the pains and rigors of withdrawal from alcohol and where he has poured out his suffering soul to his counsellors. He feels better and may seek and accept a superficial solution. At this point the wise therapist must also avoid the trap and must help his patient to accept the necessity of facing the inevitable problems of a sober life and indeed inspire him to welcome such a life as a challenging adventure.

A Feeling of Worth, Then Surrender

The experience of surrender stands between a prior acceptance of one's value as a person and a subsequent action of self-examination. Unless somehow a patient can see value and preciousness in his life, the surrender experience is unproductive and depressive. If his life is expendable and doomed to the discard heap, what is the use of the effort of rehabilitation? Why bother? Probably the first step in the successful therapeutic process is the assurance that the therapist communicates to his patient that the patient's life is worth doing something about. The acceptance of surrender is now tolerable and a continuing inventory begins to make sense. The outpatient clinic program now fits into place as a welcome resource for the patient rather than an imposition.

Use of Antabuse

Let us now turn to a consideration of the use of disulfiram (Antabuse) to direct and enforce motivation for abstinence. It has been used with a variety of objectives. For example, it has been thought of as a "pharmacological fence" surrounding the patient to interdict alcohol consumption. In our experience, the adjunctive administration of disulfiram is of no value if it symbolizes imposition of an abstinent state by the therapist, the patient's spouse, or anyone other than the patient. It is felt that disulfiram is effectual only if the patient monitors its use himself and if he employs it as a part of his daily acceptance of his own need for sobriety as a way of life. Patients in the Division are allowed to volunteer for disulfiram if medical and psychological examination reveals no contra-indications such as convulsive disorders, cardiovascularrenal diseases and diabetes. Patients who are geographically

unstable and have no fixed home are generally unsuitable cases for disulfiram.

Disulfiram is usually commenced on the fourth or fifth day of hospitalization. Previously, it was standard practice to begin with 1.5 grams on the fifth or sixth day after admission with 1.0 grams the next day and 0.5 grams on the two following days. On the fourth day after initiation of disulfiram the patient received approximately 30 cc of 90 proof whisky and endured a disulfiram-alcohol reaction. This reaction is not considered a conditioning stimulus nor is disulfiram therapy an aversion treatment.

Reaction Test Abandoned

Analysis of results of therapy showed that disulfiram patients who experienced the planned reaction test did not have a significantly different eventual rehabilitation record from those who did not. Therefore, the disulfiram-alcohol reaction was abandoned and patients have subsequently been placed on a daily maintenance dosage of 250 mgs. on about the fourth day of hospitalization. This dosage is continued during the period of outpatient therapy. In general, patients remain on disulfiram for at least a year, but some continue for two, three or more years. No toxic manifestations of long-term disulfiram use have come to light. The major side-effects may be drowsiness and sexual sluggishness which are satisfactorily handled by reducing the daily dose to 125 mgs. As indicated, the patient monitors his own disulfiram. He is asked not to take his daily dose without renewing beforehand his acceptance of the fact that he cannot drink, and choosing another day of abstinence. Thus the patient retains the privilege of making his own decision about sobriety each day. He takes the disulfiram as an act of personal decision. If he cannot accept his alcoholism and voluntarily choose another day of sobriety he is advised not to take the disulfiram and to contact his clinic physician.

Disulfiram Patients Did Better

An analysis of a group of 1020 disulfiram patients contrasted with 484 controls (1) shows that the former are a younger group with a peak in the 35-39 year-old category (the peak for the controls being in the 40-44 year-old category). So the selection processes in our program result in the acceptance of disulfiram by a

younger group which is healthier and more highly motivated. Disulfiram is rejected by or denied to older patients with more profound deterioration. Of the disulfiram patients, 76.5 per cent are classified as improved whereas 55 per cent of the controls are so classified. (A t-test of significance between the improvement scores of the disulfiram and control groups gives a "t" value of 8.3 and a "p" of less than 0.01.) Therefore, the disulfiram patients did significantly better than the controls. Likewise, male patients show significantly better records than females (male disulfiram patients, 77.4 per cent improved; female disulfiram patients, 67.3 per cent improved; "t" equals 2.1, "p" less than 0.05). The differences between the control males and the control females are not significant but there is a significant difference between the male disulfiram patients and the male controls as well as between the female disulfiram patients and the female controls. Of age categories where significant percentages may be derived the disulfiram group between the ages of 40 and 44 achieved the best clinical record. In evaluating the improvement scores it is found that the significantly better record of the disulfiram patients shows up particularly in those categories of patients in which a stable alcohol-free pattern has been established after one or more drinking relapses. The disulfiram group have a much better record of follow-up in the outpatient clinic than do the controls, and it has been hypothesized that the disulfiram principally acts to differentiate and select those more highly motivated patients who will continue long-term treatment more faithfully.

To test the motivational hypothesis, an analysis of the data was made on those patients who actually followed up and kept contact, excluding those who dropped out early or with whom contact was lost in both the disulfiram and control groups. Comparing 928 disulfiram patients who continued therapy with 333 such controls, it was found that 81.4 per cent of the former were in the improved category while 79.8 per cent of the controls were so classified, a difference not considered clearly significant ("t" equals 1.7; "p" between 0.10 and 0.05). An earlier study (2) has shown that patients denied disulfiram although they had volunteered for it had a better record than those who declined it. Of 69 patients denied disulfiram on physical or psychological grounds, none discontinued treatment early and 62.3 per cent were assigned to the improved

category. In contrast to this, 30.9 per cent of 152 patients who declined the medication discontinued treatment early and only 44.0 per cent could be classified as improved. It thus appears that those who volunteered for disulfiram and were denied it constituted a rather highly motivated group who may have accepted the disqualifying disorder as a challenge to a rehabilitative effort.

Presumed Metabolic Deficiencies

Our own investigations of therapeutic adjuncts based upon an attempt to correct presumed metabolic or hormonal defects in alcoholics have not brought to light clearly effective modalities. In 1955 Hoff and Forbes (3) explored the possible effects of long-term administration of a polyvitamin formula upon the drinking pattern of patients treated in the Medical College of Virginia outpatient clinic of the Division. In this study in which patients were evaluated after one, two and three years following the onset of treatment, a statistical analysis indicated that any differences in clinical success (based on abstinence, job and social adjustment) between the vitamin and control groups could not be assigned confidently to an effect of the vitamins but could be explained by random variation. Although patients in the vitamin group felt better than those in the control group it was not possible to demonstrate that prolonged administration of high vitamin doses to patients in any way affected their recovery. There was never any evidence that any patient acquired any degree of control over the use of alcohol whether taking vitamins or not. On the basis of studies by Hoffer and Osmond (4), Hoffer and Payza (5), Jantz (6) and Fleetwood (7), preliminary trials have been conducted on the possible value of leuco-adrenochrome. This substance in amounts of 15 mgs. sublingually four times a day appears to have been effective in abolishing tremor in tense patients, all of whom have complained of tremor especially under emotional stress for prolonged periods.

Protection Against Autonomic Dysfunction

Studies of Hoff and colleagues (8, 9, 10) have established in experimental animals and in man cortical and subcortical mechanisms of visceral control. Stimulation of isocortical, paleocortical, and other cerebral areas causes alteration of systemic blood

pressure, changes in intracardiac dynamics, modifications of peripheral circulation as well as functional and vascular changes in the kidneys, gut and other organs. In both acute and chronic experiments, changes have been produced in pulmonary, coronary and bone marrow circulation as well as epinephrine and norepinephrine secretion. These cortical autonomic control mechanisms appear to be related to forms of behavior and emotional activity. Psychological dysfunction may be related at the neurological level to disturbance of these higher cerebral autonomic mechanisms. Thus neuropsychopharmacological agents which can be shown to protect the autonomic system from higher cerebral over-response to stress may have adjunctive value in long-term rehabilitation of alcoholics.

Recently Carroll, Hoff, Kell and Suter (11) have shown that chlordiazepoxide (Librium) does in fact block cerebrally induced cardiac arrhythmias while not disturbing salivation or gastrointestinal function. As measured by its effect upon such centrally-induced autonomic responses, alcohol appears to be a defective tranquilizing agent and whereas chlordiazepoxide acts to protect the viscera from harmful cerebral autonomic dysfunction, alcohol is an imperfect attenuator of centrally-generated autonomic disturbances.

Significant Improvement Noted

A recent clinical investigation (12) of the use of chlordiazepoxide in a group of outpatients in the Medical College of Virginia clinic of the Division confirms the implication of these experimental studies. Fifty patients received chlordiazepoxide (10 to 25 mgs.) by mouth four times a day for approximately a year while attending the outpatient clinic. Seventy-two per cent of these patients are classified as improved, 10 per cent as unimproved and 18 per cent cannot be classified. In contrast, 52 per cent of 50 matched control patients are improved, 16 per cent unimproved, 25 per cent unclassified, and 8 per cent discontinued treatment early. The difference in the improvement of the chlordiazepoxide group over the control group is significant at the 5 per cent level. (X^2 equals 4.24; "p" equals 0.01 - 0.05.) The follow-up rate in the chlordiazepoxide group is higher than in the controls and repeated medical and psychological testing at the time of elective re-hospitalization has revealed no toxic changes in the chlordiazepoxide group. This

group of patients not only had fewer missed appointments but also showed greater willingness and ability to explore and face personality problems and life situations. There was less overt tension, better sleeping and eating as well as abatement of psychovisceral symptoms.

REFERENCES

1. Hoff, E. C. The use of disulfiram (Antabuse) in the comprehensive therapy of a group of 1020 alcoholics. Connecticut St. Med. J. 19:793-797, 1955.
2. Hoff, E. C. and McKeown, C. E. An evaluation of the use of tetraethylthiuram disulfide in the treatment of 560 cases of alcohol addiction. Amer. J. Psychiat. 109:670-673, 1953.
3. Hoff, E. C. and Forbes, J. C. Some effects of alcohol on metabolic mechanisms with applications to therapy of alcoholics. pp. 184-193 in: Origins of resistance to toxic agents. Ed: M. G. Sevag, Roger D. Reid, and Orr E. Reynolds. (Proceedings of the symposium held in Washington, D.C., March 25-27, 1954) New York; Academic Press; 1955.
4. Hoffer, A. and Osmond, H. Concerning an etiological factor in alcoholism. The possible role of adrenochrome metabolism. Quart. J. Stud. Alc. 20:750-756, 1959.
5. Hoffer and Payza, A. Adrenochrome levels in plasma and cerebrospinal fluid. Annual Meeting, American Psychiatric Association, San Francisco, 1958.
6. Jantz, H. Uber Stoffwechseluntersuchungen bei Alkoholpsychosen. Zbl. ges. Neurol. Psychiat. 137:141-142, 1958.
7. Fleetwood, M. F. Biochemical experimental investigations of emotions and chronic alcoholism. pp. 43-109 in: Etiology of chronic alcoholism. Ed: O. Diethelm. Springfield, Ill.; Thomas; 1955.
8. Hoff, E. C. and Green, H. D. Cardiovascular reactions induced by electrical stimulation of the cerebral cortex. Amer. J. Physiol. 117:411-422, 1936.
9. Green, H. D. and Hoff, E. C. Effects of foradic stimulation of the cerebral cortex on limb and renal volumes in the cat and monkey. Amer. J. Physiol. 118:641-658, 1937.
10. Hoff, E. C., Kell, J. F., Jr., Hastings, N., Sholes, D. M., and Gray, E. H. Vasomotor, cellular and functional changes produced in kidney by brain stimulation, J. Neurophysiol. 14:317-332, 1951.
11. Carroll, M. N., Jr., Hoff, E. C., Kell, J. F., Jr., and Suter, C. G. The effects of ethanol and chlordiazepoxide in altering autonomic responses evoked by isocortical and paleocortical stimulation. Biochem. Pharmacol., 8:15, 1961.
12. Hoff, E. C. The use of pharmacological adjuncts in the psychotherapy of alcoholics. Quart. J. Stud. Alc. (1961, in press).

Letter From An Alcoholic —

Lack of Compulsory Treatment Criticized for Those Who May Harm Selves or Others

London, Ontario,
July 26, 1962.

Dear Sir:

As the 1961 Annual Report indicates, the Alcoholism and Drug Addiction Research Foundation is making great strides in research, and is attempting to educate the professional and lay people on the problems of alcoholism. However, I think that the time is over-ripe for the Foundation to begin treating the alcoholic guinea pig as an individual, rather than as a statistic.

I realize that the alcoholic who is accepted for treatment by the Foundation is given all the help possible to enable him to lead a sober and more sane life. For the past two and a half years I have been receiving treatment from the London Branch, under the most able direction of Mr. C. Aharan and his staff. With this help and my own willingness to accept treatment, I have been able to remain sober, and my mental and emotional attitudes have undergone a marked change.

As for those who require compulsory treatment, I do not propose that the more than 90,000 alcoholics in Ontario should be rounded up and placed in Ontario Hospitals. In my opinion, Ontario Hospital is the last resort for the alcoholic; an institution that does little more than dry out the patient and then release him.

That was my own experience in 1956. I was committed to Ontario Hospital, St. Thomas, and remained there for about six weeks, the usual length of time for an alcoholic, give or take a week or two. In that time I received three private interviews, two shots of paraldehyde and about three sleeping capsules. I will say that my commitment was justified; *but there is no justification in*

commitment without adequate treatment. I had been drinking heavily at that time and my behaviour had become very erratic and unpredictable. Written on my admission slip was the fact that I may possibly be suicidal; yet I was released within a relatively short time to continue my drinking. How can any beneficial change take place with no treatment and within such a short period of time?

If an alcoholic is a threat to himself, to his family, or to the community in which he lives; if he has attempted suicide, or if his behavior is so erratic and unpredictable that he is considered to be a dangerous person, then the only answer that I am able to understand is compulsory treatment.

You are probably aware of what happens to this type of person under existing conditions. He is either jailed as a criminal or sent to Ontario Hospital to dry out. This person will seldom come into the Foundation's clinic for any prolonged treatment; it is almost impossible to reach him, and yet, he wants, and needs, help. Now I agree that there are those alcoholics who do not want help; but there are also the people who have made tentative contact with the Foundation clinic. These are the people who are aware of their need for help, but for some reason, are afraid to accept it.

A former acquaintance of mine was a very good example of this type of person. He had made contact with the clinic, but would not, or could not, accept any private therapy. Eventually, he was admitted to Ontario Hospital, Toronto. After a stay of about five weeks, he was released. Shortly after, he was jailed on a drunk charge and hanged himself in his cell. This is not one isolated case; there have been far too many suicides and attempted suicides of people, who up to now, have been unable to accept help, but who have had some contact with the Foundation or some other agency.

I have posed the question of compulsory treatment to many people, professional and otherwise. The response is almost unanimous in favor of the need for this type of treatment; yet most of these same people say that such a proposal isn't possible because of the legal aspects.

WHAT LEGAL ASPECTS?

Apparently, forced treatment interferes with the alcoholic's personal freedom. Compulsory treatment also interferes with the personal freedom of the schizophrenic and other mentally ill people. As it is, the drinking alcoholic has little personal freedom or choice. The opinion that the public has of the alcoholic has changed little, despite the efforts of the Foundation. He isn't considered to be a sick person, he is a drunk, and treated as such in many cases; usually, he is thrown in jail. (Incidentally, I have been there too and they offer no treatment either.) Eventually, he is sent to Ontario Hospital, another dead-end.

On page 67, of the Annual Report, under the heading of "In-Patient Service," you too, by your own admission, are guilty of turning away the "grossly disturbed" alcoholic. *Where can he go?*

Although you use some very fine words and fancy phrases to describe in detail what you are doing and what can be done by others to improve the alcoholics' lot, you give me the impression of talking about the "normal" alcoholic, if such a person exists. What about the "grossly disturbed" alcoholic? Are you going to continue to shut him out, to lock him away out of sight; to continue to disregard the moral obligation you have to this type of person? He is a very pathetic part of the problem of alcoholism. He deserves his chance too. Segregate him from Ontario Hospital and provide him with adequate treatment.

Surely Sir, after more than ten years of research, the Foundation must be prepared to reach out and broaden its horizon to take in these people. Or does the possible adverse opinion of the public intimidate the Foundation?

Commitment and treatment on a compulsory basis of the grossly disturbed alcoholic has been talked about before, but nothing has been done about it.

Why not try to have this proposal put into effect? You may even be responsible for saving someone's life.

Yours Sincerely,
Les Bradbury.

Addictions

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Volume 9, No. 2, Autumn, 1962

ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspect of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (365-4545)

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Addictions

AUTUMN, 1962

One of the barriers in the way of more adequate medical treatment of alcoholics is the difficulty experienced by physicians and others seeking to have such patients admitted to some general hospitals. Some hospital managements and staff members — like other people in the community at large — may have an unconscious fear of the alcoholic patient, possibly because of unpleasant memories of "Skid Row" alcoholics. This may set them against the admission of all alcoholics, whether or not such alcoholics are troublemakers. Fortunately, there are increasing numbers of communities where hospitals and local agencies are working together to overcome this problem — to the benefit of the hospital concerned, the community, and the alcoholic.

A shining example of this working arrangement is found in Sault Ste. Marie, Ontario, where the two general hospitals, physicians, and the local Alcoholics Anonymous group have developed a harmonious relationship of close cooperation.

In the following pages, ADDICTIONS presents the view of the American Medical Association towards the admission of alcoholic patients to hospital; a full account of the working arrangement found in Sault Ste. Marie; and a footnote on the experiences of St. Michael's Hospital, Toronto, in treating alcoholics. We believe these articles should indicate to other hospitals and community agencies how they can cooperate to achieve similar results.—N.S

American Medical Association Supports Admission of Alcoholic Patients to Hospital

The problem of the hospitalization of patients with the diagnosis of alcoholism has been carefully considered by the Council on Mental Health of the American Medical Association and its Committee on Alcoholism. A report and resolution on this subject was submitted to the Board and approved for presentation to the House of Delegates for its action in 1957. The statement follows:

"One of the most consistent complaints of physicians who wish to care for patients with a diagnosis of alcoholism is that many hospitals will not admit such patients. Many hospitals feel that these people are intractable, uncooperative, and difficult to handle. Because of untoward behavior, hospital authorities feel that they are not equipped to take care of the medical treatment of such overactive patients. Where such patients are unruly and uncooperative, this attitude is understandable. However, for many of these sick people who express a wish to be treated in a general hospital, it has been generally found that cooperation is forthcoming and that no special attention or equipment is necessary for treating these patients. Hospitals should be urged to consider admission of such patients with a diagnosis of alcoholism based upon the condition of the individual patient rather than a general objection to all such patients. Such objections have been very frustrating for physicians who wish to treat these patients and often discourage them from taking a greater interest in alcoholics.

"The Council on Mental Health, therefore, urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic alcoholism should not be considered as an illness which bars admission to a hospital, but rather as

qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency." ■

A Working Arrangement

By Jack K.

In Sault Ste. Marie, as elsewhere, hospitals are overcrowded and understaffed, and doctors are busy. Some few years ago, it was extremely difficult to obtain hospitalization or medical treatment for alcoholics and then, only in extreme cases. This situation was aggravated by the fact that alcoholics were commonly regarded as victims of over-indulgence rather than illness.

Today, a close working relationship has grown up between local hospitals, a good number of physicians, and Alcoholics Anonymous. Through this arrangement, alcoholics in genuine need of such facilities and services can generally obtain them. A number of circumstances served to bring about this change which was first noticeable in 1955 and 1956. The principal ones have been:

— the acceptance by many of the younger and middle-aged physicians of the modern medical theory of alcoholism as a distinct and designated disease.

— the extreme shortage of hospital accommodation during war and post-war years has been at least partially alleviated. This also applies to the availability of doctors.

— a working arrangement which has been developed between A.A. and the hospitals, and which is proving to be most beneficial in securing hospital admission for alcoholics.

It is this last point, which is, perhaps the most important, that needs further explanation.

Alcoholics in such an advanced or acute stage as to need hospitalization, require, at best, a great deal of surveillance and

attention. Frequently, they require constant restraint, and generally speaking, they are a source of considerable trouble in a hospital. With the best intentions in the world, the average hospital is not in the position to furnish all this attention, nor to cope with all the problems that an alcoholic patient can present. This has always been the great stumbling block in obtaining the admission of alcoholic patients.

This stumbling block has been overcome in Sault Ste. Marie. Here, an arrangement has been worked out under which Alcoholics Anonymous promises to furnish members of their Fellowship, on an around-the-clock basis when necessary, to provide the constant surveillance that the alcoholic might need. The hospitals have come to realize that they can rely on the promises of A.A., and this has relieved them of one of their principal difficulties.

A.A. - Doctors Cooperate

Admission of an alcoholic to the hospitals is made only on the recommendation of a physician. Physicians are, in fact, usually the first to be called in on such cases. When hospitalization is a necessity and constant attention for the patient required, some doctors call on A.A. to complete arrangements for admission; in other cases, the hospital will call on A.A. In still other cases, the need for continuous surveillance does not become apparent until after hospitalization, and A.A. is then contacted. On occasion, A.A. will be called in first by a relative or friend of the sick alcoholic. Usually, an experienced member will try to decide if medical care is actually needed, and, if so, will arrange for a doctor. There are several doctors in Sault Ste. Marie who are particularly sympathetic to the problem of alcoholism and who know that they can rely on any assistance A.A. can proffer.

Briefly then, this working arrangement rests on A.A.'s undertaking to provide such surveillance as may be necessary; to render such other assistance as their capabilities permit in the case of all alcoholics admitted under their auspices; and to work in close cooperation with the hospital and attending physicians. It should be noted that in all such cases, the doctor remains responsible for

the treatment necessary (and the degree of restraint required); and the hospitals responsible for the medication and care of the alcoholic patients. These matters are far beyond the proper province of A.A.

Stress must be laid on the fact that A.A. cannot make itself responsible for transients or unknown persons. There are many reasons, some of them legal, why this is not advisable and why such cases must be left to the responsibility of duly constituted welfare agencies. A.A. does stand ready, though, to do what it can in these cases as well.

How A.A. Members Help

A few other observations may be of interest:

— A.A. members attending alcoholic patients do not leave them until hospital supervisory staffs are satisfied such patients will not cause further trouble.

— A.A. tries to have these patients met by a member on discharge.

— physicians and surgeons have addresed the local A.A. discussion group to the advantage of both.

— nurses from local hospitals have also addressed the A.A. group; their sympathetic interest and understanding were particularly noticeable. A nurse from each of the local hospitals attended a summer course on alcohol problems sponsored by the University of Toronto and the Addiction Research Foundation of Ontario.

— on occasion, A.A. has assisted the hospitals in the surveillance of non-alcoholic mental patients and this has been duly appreciated.

— in the case of non-members, A.A., when in attendance, does try to carry its message to those patients, and A.A. literature is available in the hospitals at all times. A.A. members also try to visit other patients, who, although not under A.A. care, are known to have an alcoholic problem and who have expressed an interest in A.A.'s solution.

— A.A. maintains a local telephone answering service through which available members can usually be located fairly rapidly. The local hospitals, and some of the doctors, are also quite familiar with key A.A. members.

— in the case of larger employers, A.A. maintains close contact with company doctors and personnel departments.

In some 25 cases brought to the attention of the writer in recent years, no local doctor has refused to have a patient admitted to hospital when A.A. undertook to assume responsibility for the extra attention or restraint required. Nor have the hospitals ever refused such admissions, even when sorely pressed for accommodation. For its part, A.A. has endeavoured to fulfil its pledges.

Basically, in all its dealings with doctors and hospitals, local civic authorities, clergymen, publicity media and the public, A.A. has tried to prove that when it does seek help, it also tries to provide it.

The General Hospitals: Their View of This Working Arrangement

Sault Ste. Marie General Hospital

Here, in the words of Sister St. Kevin, Medical-Surgical supervisor, and Miss Violet Glibota, head nurse, is how the Sault Ste. Marie General Hospital cares for alcoholic patients:

"When an alcoholic arrives on the ward, he is given the same consideration as any other patient. Alcoholism is considered an illness just as any other disease. The nurses, who have studied the causes and treatment of alcoholism, are interested in helping the alcoholic.

"The patient is encouraged to receive a visit from a member of Alcoholics Anonymous. If he refuses, and the nursing staff finds it difficult to manage him, an A.A. member is usually contacted by the nursing supervisor through the A.A. answering service.

"A.A. members do everything possible to help; they are very cooperative and will even consider language barriers and individual idiosyncrasies. Generally, two A.A. men spend eight hours with the patient and arrange to relieve the next shift. This is very helpful on the afternoon and night tours of duty when nursing staff and orderlies are unable to spend time with these patients.

"The company of A.A. members seems to relax alcoholic patients; they know they are speaking to people of their own kind who have had similar experiences. They are reassured, and encouraged to cooperate with the nurses.

"At times, this can cause a problem. If the patient is in a large ward, and wishes to talk to the members sitting with him on the 11 p.m. to 7 a.m. tour of duty, he may disturb other patients. Even overhearing a conversation may lead other patients to ridicule the alcoholic, thus causing him to become hostile and difficult to manage. However, there is a positive side to this. Perhaps the man in the next bed has the same problem, but refuses to recognize or admit it. Through A.A., he is helped indirectly to seek advice after his discharge." ■

Plummer Memorial Public Hospital

Agatha Wilson, Director of Nursing at Plummer Memorial Public Hospital, Sault Ste. Marie, describes how her hospital cares for alcoholics:

"Alcoholics are admitted to the Plummer Memorial Public Hospital, and the nursing staff prefers to have them admitted under a diagnosis of alcoholism rather than under a disguised diagnosis. Alcoholic patients are nursed in wards unless they are uncooperative when being admitted, or if unknown alcoholics are admitted under another diagnosis and develop delirium tremens. The advent of tranquilizers has helped a great deal in caring for these patients.

"Certain members of our medical association are interested in alcoholism and assist the Alcoholics Anonymous group in

solving the problems of alcoholic patients. The attitudes of these doctors towards this disease influence the nursing staff.

"The members of the Alcoholics Anonymous group in this city are always willing to give assistance when needed. We know we have only to make a telephone call and a member or members of the group will be here to help us. One of the local ministers, who inquired about A.A. members visiting patients at times other than visiting hours, was given four red cards which permits the persons presenting them to visit a patient without question.

"Pamphlets on alcoholism are kept in our wards and are available to patients and visitors. The A.A. group has also assisted educationally by sponsoring one of our head nurses to a seminar on alcohol problems. In addition, members of our staff are invited each year to the A.A. conference.

"Just a few years ago, mental patients were kept in jail while awaiting admission to a psychiatric hospital. Members of our hospital's Board of Directors were concerned about this, so that when they were planning a new wing for the hospital, they included two detention rooms. This foresight has aided the nursing staff in caring for unmanageable patients.

"It is rewarding for us to see our patients taking their places in society and becoming useful citizens in their community." ■

A.A.'s Official Policy of Cooperation

The following statement is the official policy of Alcoholics Anonymous regarding cooperation with hospital authorities:

"In many cities, A.A. has developed a pattern of cooperation with general hospitals that has been of great benefit to the alcoholic in his recovery program. Frequently, the hospital designates one section for alcoholic patients under specific conditions for admission, providing that: patients have no complications, other than alcoholism; patients themselves wish to be hospitalized; patients wish to

solve their drinking problems; and patients have the necessary funds to pay hospital fees. Traditionally, full control and supervision of the program is reserved to the hospital.

"In many instances, alcoholics are admitted to the alcoholic section only through the A.A. Central Office (Intergroup). The Central Office arranges for an A.A. sponsor to accompany the patient upon admission and to meet the patient upon completion of treatment. A.A. volunteers may also assist the hospital staff with non-professional duties and may visit with patients." ■

Freddy B.'s Story

I am an alcoholic. My name is not important. It is over a year now since my last drink, and I can now put down something of my story. This is not done out of pride or ambition — I remain anonymous. Nor is it done out of a sense of drama or warning — you can't really scare an alcoholic into sobriety. I write this in gratitude — I have so much to be thankful for!

My story begins over a year ago in the St. Mary's River near Sault Ste. Marie. I am seated in my car, a short distance from the shore, with the icy, smelly water of the river up to my neck. A lifetime of uncontrolled drinking and the attendant mental turmoil have put me here. I am not drunk — I am insane. Utterly and certifiably insane! I have had all I can take from the old Master Liquor. I have tried to fight my way to sobriety by myself. By myself, I can't do it!

I am aware of the events preceding my arrival here, in the water, and I am aware of what is going on around me — some of the things. I am not to learn for a year that the police are looking for my car and me. The police radio message is laconic — "he left his residence on the hill — his landlord reports he was acting strangely." Two uniformed men, then unknown to me, hear that call. One is on a suburban force and is to have an important effect on my later life; he is a member of A.A. The other is on riverfront

patrol and sees my car out in the water. The radio had said it — "he was acting strangely." I have a tremendous respect today for the courage of this man, who commandeers a ride in a flat-bottomed punt to approach an unknown lunatic. He is a young man, a family man. Through the nature of his work and his training, he is well aware that he is taking his life in his hands. This is just so many words in a novel; but these things do happen in real life. He does not pull a gun to protect himself; he shows no fear or hesitation.

"Cop" — A Pleasant Word

The entry of the police into the dream world in which I am living gives me no indication of the tenseness of the situation. I see only a friendly man in a blue uniform who speaks to me quietly and pleasantly. It seems I can respond when he tells me what to do, and I hang onto the edge of the boat as they row for shore.

As they put me in the police cruiser, both he and his partner are pleasant and friendly — they keep me talking. Their every word and gesture is designed to foster an atmosphere that convinces me that they are my friends and are only trying to help me. Now, I know that they could not be getting very much sense out of me. I am filthy and smelling of the vile river water. Water from a busy harbour anywhere stinks!

I remember very little now of my time at the station or the subsequent trip to the hospital — just glimpses here and there. Through it all runs the knowledge that I was in good hands, that I was amongst those who would help me. To the day when I go to greet my Maker, I will remember these men with gratitude. "Cop" is a pleasant word to me today — a word and a thought of respect.

Parents Never Give Up

Despite years of heartbreak and disappointment, parents never give up — not really. Mine are in a distant city, and for years, we have been separated by much more than miles. My employer

informs them of what little he himself knows. They come — fearing the worst, hoping very faintly. My father is a proud and successful man, and it is a very bitter pill to have to approach strangers at a police station in a strange city to enquire into the state of the only son in whom he took such pride many years ago. He met different men than I, but the reception he got has left a lasting impression on him. He continually refers to these men as a force trained and dedicated to helping the public. That impression is today as strong with my parents as it is with myself.

I am fortunate and sanity soon returns. I am lying in a hospital bed and feel that I am under sedation. I am well aware that hospitals find dealing with an alcoholic a thankless and heart-breaking business. They do not know what to expect — violence, filth, foul language and the apparent desire only to return to the hell of a drinking life at the first opportunity. To those who are dedicated to a life of service and betterment, an alcoholic must appear as understandable as a visitor from outer space. However, they do not draw away from me as a pariah — all I could honestly expect. They are pleasant and very, very kind. Without the sedation, my nerves and emotions would be uncontrollable; with it, I am just weak and helpless. They look after my needs and relieve my mind. I am on the road to recovery.

A.A. Door Is Opened

Another day, and I am well enough to phone the police from the hospital. Fearing the worst, I am relieved. I have hurt no one and no charges are against me. They tell me that the officer who brought me in is out on patrol and will drop in if I would like to see him. I would! I am a little surprised to recognize him when he enters the room — something like having a part of a dream turn up in real life. We talk, and I tell him of my alcohol problem. His duty in my case is finished, but he goes out of his way to tell me about an A.A. friend of his who is also a policeman. He goes further and contacts this friend, and asks him to come and see me. His friend does come to see me, and the door to a wonderful life in A.A. is opening for me.

The doctor who was on emergency duty, attends to me for possible exposure damage — chest x-rays, etc. He is an extremely busy man, and has undoubtedly dealt with alcoholics before; he knows that the majority will repeat — that his professional skill is more needed by other sick persons, ones he knows that he can cure. He takes the interest, however, to enquire if I would see the hospital psychiatrist and when I agree, he is very prompt in arranging a consultation.

Today, I recognize the importance of this new contact in my life. He is a psychiatrist and a specialist in internal medicine with, moreover, a sound knowledge and belief in A.A. and its principles. He understands alcoholics as much as a non-alcoholic can — he understands me! He sets up the course of treatment I desperately need and arranges for its continuation. I have only been in this city a short time and have no regular doctor. I visited one once while under the influence. He could do nothing for me and knew it, but he does accept me as his patient so that I can stay at the hospital for a few days.

Hospitals and A.A. — Mutual Cooperation

I also talk to one of the senior nursing sisters who, I find, has a regular contact with an A.A. member. She goes to considerable trouble to locate this man and also to chase around the hospital to find a copy of the A.A. book for me.

Various A.A. members visit me during the ten days that I am at the hospital. They all speak in glowing terms of the hospital and its staff. Many have been hospitalization cases themselves. I also notice that they are not always restricted to hospital visiting hours. In turn, talking to some of the nurses, I hear them speak very highly of A.A. This atmosphere of mutual cooperation has a terrific impact on me and prepares the way for my entry into an active, sober life with my new-found A.A. friends.

Many people have helped me during the past year; more during the period of this little story. I couldn't include them all. I know now that not all alcoholic cases are hopeless — that this is a sickness that can be arrested. I number among good friends many with a

decade or more of sober, useful lives of service to their fellow man.

I am very sincere in my thanks to the God that brought me to Sault Ste. Marie. I well know that without this directing influence, things would be very different for me today. I see a vision of a being that could very easily be me — a derelict, penniless, jobless, cut off from family and friends — from God and life itself — shuffling aimlessly and hopelessly along the drab back lanes and sordid alleyways of some distant city. I have seen these places — they exist in every city — to which derelicts drift while the last flicker of hope and life wanes away. This is not a vision formed only of inexperienced dreams — I have friends in these places. Some will come back — many will not. Only the selfless help of many has prevented that vision from becoming a reality for me.

Alcoholics in the General Hospital — The Experience of St. Michael's Hospital

*By W. E. Hall, M.D., F.R.C.P.(C)**

It is possible to treat acute alcoholic intoxication in hospital very quickly and effectively by well tried methods. In fact there are few medical conditions which respond so rapidly and so well to specific therapy as does this form of intoxication.

The first step in the successful treatment of the acute alcoholic is to make him feel that he is being accepted as one who is ill. He requires encouragement and must be approached sympathetically. He must not be aware of resentment on the part of the doctors, nurses or attendants. If he is shown resentment he will in turn become resentful and develop into a behaviour problem.

Many hospital administrators, nurses and staff doctors have an

* This is condensed from an earlier paper by Dr. Hall in the March, 1955, issue of this publication. At that time, Dr. Hall was the staff physician at St. Michael's Hospital in charge of patients referred by the Foundation. Dr. Hall, who is an Associate Professor of Medicine at the University of Toronto, is a staff physician in the Department of Medicine at St. Michael's. Since 1957, Dr. Alick Little has been in charge of such patients referred by the Foundation.

unconscious resentment toward, and a fear of, the acute alcoholic. They look on him as one who should not have allowed himself to reach such a state. They neglect, or are unaware of the fact that the man has a strange, poorly understood disease. Like many lay people they look at the disease as a self-inflicted one which will not kill the patient; and therefore they feel that there are others who need the hospital's services more.

Sources of Resentment

Hospital personnel may have unpleasant memories stirred up by the word "alcoholic". They recall the "Skid Road" alcoholics who have gone through the emergency ward with lacerations, fractures and head injuries. The burdens which these individuals have brought to the hospital in the form of intoxicated friends, crying families and enquiring police come quickly to mind, and resentment is aroused toward the acceptance of another alcoholic inside the hospital. The hospital staff does not make any distinction between the psychopathic alcoholic and the non-psychopathic alcoholic who is not a troublemaker.

The vast majority of patients with acute alcoholism are not noisy, injured or encumbered by police and relatives at the hospital door. For the most part they are fairly responsible citizens who are very ill and in great need of specific treatment. If treatment is given they will be restored to a relatively good state of health in a few days. If treatment is not given they will become more severely ill and continue to be the despair of themselves and their relatives for an indefinite time.

Why Treat The Alcoholic?

Practising physicians are all very much aware of the havoc which alcoholism creates with respect to his patient's health, family and prestige. When it is possible for the hospital personnel to see the alcoholic from the point of view of the family physician and thereafter to admit the patient as a deserving individual, the major step toward recovery has been taken. The next few stages are clear-cut and certain to produce complete recovery from this par-

ticular episode in this illness. It is vital, however, that the physicians and nurses undertaking treatment of alcoholics realize that the improvement in health will be only temporary unless the patient proceeds to further help with his many problems. "Sobering up" the alcoholic merely represents the termination of one acute episode in a prolonged chronic illness. The treatment of acute intoxication should be the first step in a program of rehabilitation.

What sort of patient is the alcoholic when he reaches the ward? One of our nurses with three years' experience in handling alcoholics has said: "Alcoholics are interesting people to treat. If you treat them from the first as sick people and never let them feel that you are looking at them as just another drunk, they are easy to handle. If you humor them and have the right attitude towards them they will accept whatever treatment you want to give them. After 24 hours they are very cooperative and more appreciative than the average patient. They recover so fast that they break the monotony of the ward."

Advantages of General Ward Treatment

In the literature there are many references to the advantages of treating the alcoholics on a general ward. When St. Michael's Hospital began to accept patients for the Alcoholism Research Foundation, the director suggested that the patients be admitted indiscriminately to any ward where a bed might be empty. It was indicated that it would be bad policy to have beds set aside as "alcoholic beds" and have a stigma attached to anyone admitted to such beds. Over the years the wisdom of this suggestion has been borne out. Patients have appreciated the fact that they have been treated like others. Their self-respect which returns with sobriety has not been needlessly injured. Many who have required second admissions to hospital have requested that they be admitted where they can become lost in the midst of many and not segregated in a labelled bed.

Other advantages have come from having the intoxicated and the non-intoxicated together. The chronic, moderately ill patients on the ward, who are up and about, soon learn to help in handling

the new alcoholic admission. They provide him with reassurance and kindness. They see that he stays in bed when he is likely to injure himself by being up. Thereby they take some of the work away from the nurses and orderlies. Often they help in giving fruit juice and fluids to the patient as he is coming out of his therapeutic insulin reaction. The next morning all are friends and the chronically ill patient shares some of the nurses' and doctors' satisfaction that comes with seeing someone respond successfully to treatment. In other words, the alcoholic often is an indirect means of improving the morale of the ward. The alcoholic when not drunk is frequently an extrovert and may be so jovial on recovery that he adds new spirit to a ward whose tone may have been tending towards one of depression. ■

The Urban Tavern: Some Preliminary Remarks

*By Robert E. Popham, M.A.**

If we are to acquire anything approaching an adequate understanding of the nature of alcoholism, it is clear that we have to learn as much as possible about the social contexts in which drinking (whether pathological or not) occurs.

The tavern is one such context; one in which perhaps a third of all drinking is done in the urban North American community. Moreover, it is easier to study than many of the other settings in which drinking occurs. The home and private club, for example, are much less accessible to the student of drinking behavior.

Accordingly, the investigation upon which the following comments are based, was undertaken chiefly in an effort to contribute to our understanding of drinking behavior in general and of the

* Mr. Popham is Assistant Director of Research (Behavioral Sciences) of the Addiction Research Foundation of Ontario. This article is slightly revised from a lecture he gave in June, 1962, at the summer course on Alcohol Problems sponsored by the Foundation.

social factors influencing it. Interest was further increased by the remarkable neglect of the tavern in the scientific literature. This was particularly striking when the classic studies of the modern community (which purport to be more or less comprehensive descriptions of social life) were consulted. Typically, mention of the tavern was nowhere to be found in such works. This lack of scientific attention is especially curious when it is noted that, on the other hand, there is a very considerable literature concerned with methods of controlling tavern operation, and with a diversity of social problems — particularly alcoholism — which are allegedly attributable to the tavern.

The study, which was conducted over a period of six years, was exploratory in character. The objective was purely to understand, not to judge or attempt to find any way of changing the tavern. The approach was many-sided and included consideration of historical aspects, an examination of certain widespread notions about the influence of the tavern on drinking behaviour, and, most particularly, field work designed to provide a picture of the social life associated with the contemporary tavern in one metropolitan centre.

The necessarily sketchy account offered here is intended only to highlight the principal findings in the first two of these areas of investigation. Parenthetically, the word tavern is employed throughout with reference to any licensed public establishment in which alcoholic beverages are sold and consumed with or without food. Accordingly, beer halls, beverage rooms, cocktail lounges, pubs, inns, and so on are included in the meaning of the term, provided the criteria of the definition are met.

4,000 Years of Opposition

The history of the tavern is long and interesting. It begins somewhat more than 5,000 years ago, probably in the Bronze Age cities of the Near East. The earliest written document containing mention of taverns appears to be the Code of Hammurabi which was set down about 2,000 B.C. It is peculiarly significant that the tavern's introduction to history should have been via a set of

regulations which sought to restrict its operation in certain respects.

Since the time of that famous Code, one of the most prominent features of the tavern's history is that it has been an object of attack by at least some writers in every period. Furthermore, opposition towards the tavern has been reflected implicitly or explicitly in the innumerable legislative restrictions which have been imposed upon it through the ages.

An important feature of this opposition is that it has emphasized, for the most part, what might be called the 'alcoholic role' of the tavern. That is to say, the tavern has been condemned, restricted or even prohibited primarily because of its function as a place in which alcoholic beverages are sold. The reasoning involved runs something like this: "In taverns alcoholic beverages are made available and drinking is encouraged. This inevitably leads to drunkenness which in turn, leads to poverty, family breakdown, divorce and suicide. Alcohol makes men reckless and thus leads to gambling. It also has an aphrodisiac effect and so leads to prostitution, sexual promiscuity and various related social problems. . . ."

Motive for Opposition Questioned

Doubtless in all periods there have been at least some persons whose condemnation of the tavern was motivated solely by the belief that it was indeed a source of undesirable behaviour through its encouragement of drinking. But I submit that such persons have usually been in the minority, and that a close reading of the record suggests that other motives better account for most of the persistent opposition. There are two reasons for believing this which are worthy of special attention.

First, it may be noted that throughout its history, the opposition tends to be concentrated in certain groups rather than to be scattered randomly over the population. For example, it is common to find highly unfavourable attitudes expressed by members of the uppermost socio-economic strata of society, by the church and its representatives, and by those in managerial and proprietary occupational categories. In one case which will be discussed below,

organizations of middle class women were among the most vigorous of the tavern's attackers.

What relevant features do these groups have in common? For one thing, with the exception of the last-mentioned, these are the segments of society standing to lose most by the process of social change. Also, paradoxically, these groups are among the least likely in any community to have firsthand knowledge of taverns. They are the very groups whose members are rarely numbered among the patrons of taverns. Stated in other terms, these are the persons least likely to have developed antagonism towards the tavern as a result of direct experience or observation. Yet it is from them that the most passionate excoriations of the tavern have come.

The "Saloon Problem"

A second reason to doubt the manifest motive for most opposition to the tavern is that occasionally it can be shown that this opposition persists vigorously even in the face of contrary evidence, that is, evidence which does not support the stated basis of the opposition.

Perhaps one of the best examples of this occurred at the turn of the present century. Between 1890 and 1900, the American equivalent of a royal commission: the "Committee of Fifty", set out to investigate the 'saloon problem', and a number of related matters. The best known of the works resulting from this committee was a book by Raymond Calkins published in 1901. It was called "Substitutes for the Saloon" and was the principal report on this aspect of the Committee's deliberations. In the course of its investigations the Committee employed a number of sociologists to study the saloon in Chicago, and certain other large American cities.

From the reports which these sociologists published independently, there is no indication that any of them had an emotional investment one way or the other in the outcome of their surveys. They were neither 'Dry' nor 'Wet'. They were being paid to do objective field studies and that is what they did. One of these men studied the saloons in a heavily industrial ward in Chicago. This

ward was considered one of the worst from the point of view of social problems. This is what he reported: "In visiting something over two hundred saloons in the ward at various times of the night and day, I saw just three drunken men. . . . There are in all but two saloons known to the police and to the public at large as headquarters of gangs of thieves; and there is one that is a well-known assignation house. There is no saloon in the ward which is a house of prostitution, and no saloon which is a gambler's headquarters." Another field-worker who studied a different ward in Chicago, virtually duplicated these findings.[1, 2]

Notwithstanding such results — the only objective and systematically gathered information on the topic available to the Committee — Calkins concluded that "other places of recreation [must] be provided without the perils accessory to the saloon where a man may enjoy the society of his fellows without being confronted with the evils of intoxication, of gambling, of social vice, and where he will not be tempted to squander his week's wages." This, in the face of a Committee-sponsored study which found a total of three drunken men in visits to more than 200 saloons, no evidence whatsoever of gambling, and precious little of any other kind of social problem.

The Tavern's Social Role

These considerations lead one to seek covert reasons for the persistence of opposition toward the tavern. It is suggested that such reasons may be found primarily in the tavern's 'social role', that is, in the fact that the tavern provided a particular kind of meeting place for a great many persons, rather than in the fact that it sold alcoholic beverages.

There are two kinds of evidence for this. First, there is the role of the tavern as a factor in social change. Throughout its history, the tavern has figured more or less prominently in a great variety of movements and activities which have led to both political and economic change. The Russian, French and American revolutions, for example, were all more or less intimately associated with taverns and tavern groups. In Russia, the tavern was the favourite resort of

those conspirators — if you wish to call them that — who laid the basis for the Bolshevik Movement.[3] In England after the French Revolution, very severe restrictions, even attempts at prohibition, were imposed on taverns under the guise that such establishments were sources of excessive drinking and other social problems. But it would seem almost certain that this was done because the British government feared that the revolution in France might be duplicated in England. At the time, the taverns were virtually the only meeting places available to the working classes. There they were relatively free to discuss their common oppression, and in such a setting sentiments might easily be mobilized and the seeds sown of a united threat to the political status quo.

Taverns and Social Change

To cite but one of many possible local examples, the Upper Canada Rebellion was largely planned in a tavern, and one of its battles was fought in a tavern. Nor should one forget to mention that the principal cause of the greatest conflict which mankind has yet suffered, namely the Second World War, began in the beer halls of Munich. These were the headquarters of the Nazi Party before it came to power. They were the scene of many of the early rallies of Hitler, and indeed, the first abortive attempt of the Nazis to seize control in Germany has been indelibly stamped with the origin of the movement: the 'Beer Hall Putsch'.

With respect to the role of the tavern in economic change, the outstanding example is the Trade Union Movement whose origin is closely associated with English taverns of the 18th and 19th centuries.[4] There the industrial worker could meet in relative freedom with his fellows and hold those discussions which would eventually lead to organization, and the power to bargain collectively. This was understandably seen as a very serious threat to the security of the managerial and proprietary classes of the time. It is therefore not surprising that they should condemn the pubs as dens of iniquity and drunkenness, and seek to have them restricted by law.

A second type of evidence which can be cited in support of the

argument being presented, comes from a consideration of the history of the coffee house. In Islamic countries, for example, where the consumption of alcoholic beverages is forbidden by religious law, the coffee house performs the social functions associated with the tavern in other areas. It provides a meeting place for various classes of people: a place to relax, to talk, and to drink coffee. The coffee house, like the tavern, has been a centre of political and other activities which might well be regarded as in conflict with the established social system.

The important point is that although the coffee house does not have an "alcoholic role", it nevertheless has a history of opposition at least as vigorous as that to which the tavern has been subjected. Indeed, there have been periods when "coffee drinkers were mistreated, put to the lash. The lovers of coffee had their tongues torn out or were sewn in sacks and thrown into the sea". Restrictive legislation and various attempts at prohibition have been imposed upon the coffee house, and generations of Islamic writers have castigated it in the most unreserved terms.[5] Yet the cause of concern in this instance can hardly have lain in the effects of the beverage consumed *per se,* but must be sought in the "social role" of such establishments.

A Threat to Status Quo

To sum up briefly, what I am suggesting is that the tavern, like the coffee house, constitutes a type of meeting place, sometimes the only one available, for certain segments of society. It provides an atmosphere conducive to relaxation and fellowship. This promotes the relatively free exchange of common views and grievances, and hence often the beginnings of organized groups to do something about them. Because of this it is suggested that, from time to time, the tavern has been perceived to represent a sufficient threat to the status quo, whether with respect to organized religion, the class structure of society, or to the state itself, to account for a very significant part of the persistent opposition which has been directed against it.

Whatever validity the foregoing theory may otherwise have as

a comprehensive explanation of the history of unfavorable attitudes towards the tavern, there is one notable exception which deserves mention. I refer to the condemnation and eventual prohibition of the 19th century American saloon. As noted earlier, women were especially prominent in the fight against this institution. In this regard, one has only to think of the role of the Women's Christian Temperance Union, and of some of the more famous personages associated with the Anti-Saloon League.

The saloon, it must be remembered, was not merely a source of alcoholic beverages. It was the "workingman's club", a traditionally male world from which women were excluded. As such, it represented not so much a threat to the status quo, as it did a prominent symbol of the inferior status accorded to the womenfolk of the period. Therefore, it is not surprising that women should have been so active in the Prohibition Movement: abolition of the saloon constituted a gain in a larger battle. In a word, it is suggested that the saloon was attacked not so much because it encouraged the consumption of "Demon Rum", but because it was a male stronghold. The real struggle for the womenfolk was the battle for equal rights, and it is probably no accident that many of the same women involved in the fight against the saloon were later also active in the Suffragette Movement.[6]

Does Tavern Frequency = Drunkenness?

I would like now to turn briefly to another somewhat related aspect of the tavern study.

There is today, and has been for a long time, a very widespread belief that tavern frequency (the number of taverns per unit of population) has a direct influence on the amount of alcohol consumed and the prevalence of alcohol problems in any given community. The most common view is that the greater the number of taverns, the greater the alcohol consumption and the more drunkenness. For example, in a survey of the opinions of Ontario clergymen, conducted by the Foundation some years ago, it was often suggested to us that one means to reduce the problem of alcoholism was to cut down on the number of taverns and other

liquor outlets.[7] Moreover, this belief seems to have motivated many of the legislative provisions which have sought to regulate tavern operation in this province during the nearly 200 years since the first licensing act of 1774.

In the present investigation no attempt has yet been made to undertake a definitive analysis of this alleged relationship. However, using such data as were more or less readily available, a preliminary test was made of the hypothesis that there is a simple positive correlation between tavern frequency, amount of alcohol consumed and drunkenness. Firstly, U.S. figures for per capita consumption and tavern frequency by state were examined, and it was found that the correlation approximated zero. The rate of arrest on charges of drunkenness and the number of pubs per 100,000 in the various counties of England and Wales also failed to show a positive relationship. As a matter of fact, the correlation in this case was slightly negative. In other words, there was a very slight tendency towards fewer arrests for drunkenness where tavern rates were high, and conversely, towards more arrests where taverns were fewer.

The Effect of Liberalizing Liquor Laws

In Ontario, convictions for drunkenness and tavern rates showed a quite markedly negative relationship when plotted through time. In periods when the tavern rate was high (for example, during pre-Prohibition years), the rate of conviction for drunkenness was low; when there were relatively few taverns, as during the late depression years and the wartime period, convictions rose sharply.

A possible reason for an inverse relationship is that where a larger number of taverns are tolerated, a relatively more liberal attitude towards drinking may prevail. Consequently, fewer persons are arrested for drunkenness. Conversely, few taverns may reflect a relatively low acceptance of drinking so that drunkenness is rather broadly defined and relatively many arrests are made. There are a number of other possible explanations but space does not permit consideration of them here.

One further body of data bearing on the matter of the influence

of tavern frequency on drinking and drunkenness is worthy of comment. This concerns the effect of the Liquor Licence Act of 1947 which led to an increase in the number and variety of taverns in Ontario, and permitted the sale of spirituous liquors by the glass. At the time there was much comment in the newspapers and many persons felt that such liberalization of the liquor laws would promptly lead to sharp increases in alcohol consumption and drunkenness.

What Happened in Ontario

As a matter of fact, between 1947 and 1955, per capita alcohol consumption in Ontario did increase by 18.2 per cent, and the rate of conviction for drunkenness over the same period rose 8.3 per cent. However, to conclude that these increases were caused by the Liquor Licence Act is not at all justified since it is not known for certain that the increases would not have taken place anyway. In this regard, it is instructive to note that both of these rates showed much greater increases during a comparable period preceding the Act (1938-1946) than they did subsequently; per capita consumption had already risen 58 per cent, and convictions for drunkenness 50.5 per cent.

It is also enlightening to compare the trends in Ontario with those in another province where no changes in the liquor laws took place during the relevant period. If Manitoba is selected for the purpose, it is found that the increase in alcohol consumption between 1947 and 1955 was 4.3 per cent or less than that in Ontario. On the other hand, the increase in rate of conviction for drunkenness was 32.6 per cent or greater than the increase in Ontario during the same period.[8]

A Doubtful Assumption

Many factors would have to be taken into account to establish with full confidence the effect, if any, of new liquor legislation on the prevalence of alcohol problems in a population. However, the evidence presented here at least serves to cast doubt on the conclusion that large increases in alcohol consumption and drunken-

ness convictions may be attributed to the liberalization of Ontario licensing laws in 1947.

By way of a concluding comment I would like to draw attention to some data bearing on the role of another aspect of tavern operation, namely, closing hours.

As in the case of number of taverns, it is widely thought that the period in the day during which taverns are open has a bearing on the extent and character of drinking in the community. More specifically, it is commonly held that the frequency of drunkenness is correlated with the hours of sale.

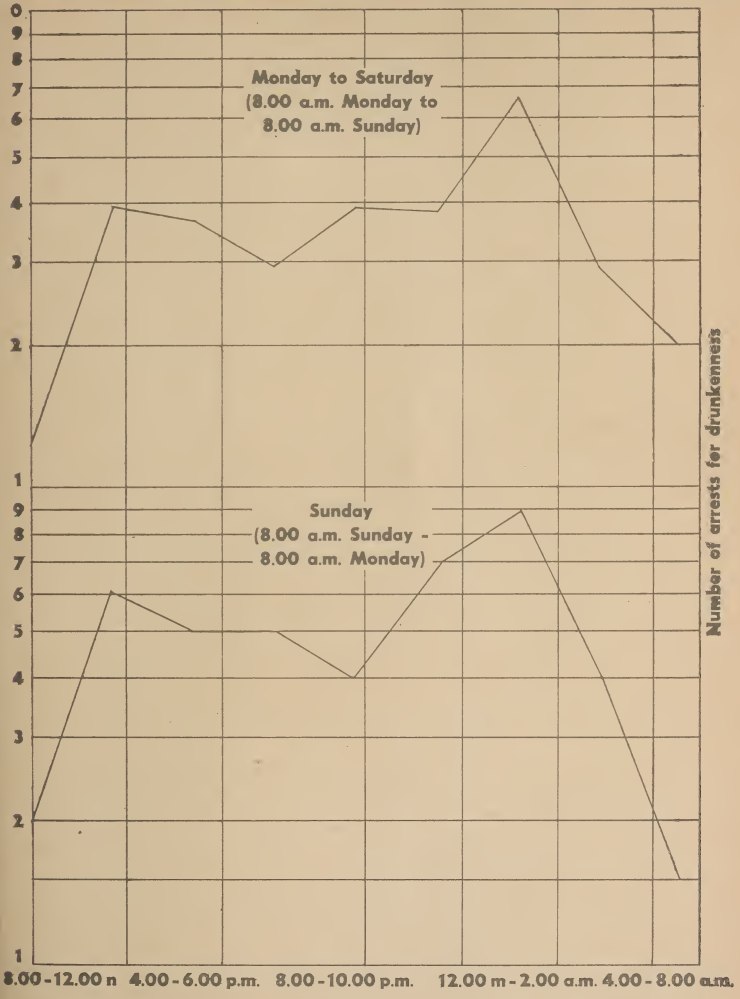
In an effort to make a preliminary examination of this proposition, figures were obtained on arrests for drunkenness in the City of Toronto by hour of the day. These were tabulated first for the period from 8.00 a.m. Monday to 8.00 a.m. Sunday. These cut off points were selected because it seemed reasonable to assume that drinking which occurred between 12 midnight and eight in the morning was in fact a part of the previous day's drinking pattern. When the figures were plotted on a graph, the result was the distinctive pattern of arrests shown in the upper half of the chart.

A "Drinking Pattern" Exists

Now it is easy to conclude that this pattern closely follows the hours during which taverns — especially so-called "beverage rooms" — are free to operate. Thus, there are few arrests in the morning when all taverns are closed. But during the noon opening hours a peak is achieved and maintained until the late afternoon. Between 6.00 and 8.00 p.m. there is a fall in number of arrests and this is the period during which the "beverage rooms" are closed. The greatest number of arrests takes place during the evening opening hours and reaches a maximum between 12 midnight and 2.00 a.m., the period when all taverns close until noon the next day.

The argument appears to be quite convincing. However, in the lower half of the chart the number of arrests has been plotted for the period: 8.00 a.m. Sunday to 8.00 a.m. Monday. It is evident that the overall pattern of arrests is almost identical to that plotted

ARRESTS FOR DRUNKENNESS IN TORONTO BY TIME OF DAY 1954



above for the remainder of the week. Yet all taverns are closed during the whole of this 24 hour period. The conclusion would appear to be that the arrest pattern is not a simple product of tavern opening and closing hours, but rather that it is a reflection of more fundamental aspects of the social context in which it occurs.

A Lesson

If there is a lesson to be learned from what has been said, I suppose it is that if we wish to devise methods of controlling tavern operation which may be expected to somehow influence drinking in our society, then we must look inside the tavern. We are not apt to make much headway by counting the number of tavern exteriors or worrying about closing hours and other mechanical aspects of operation. We must understand the human beings who patronize such establishments, the personnel who serve them, and the relations between the two. ■

REFERENCES

1. Koren, J. Economic Aspects of the Liquor Problem. Boston: Houghton Mifflin 1899, pp. 212-213.
2. Melendy, R. L. The Saloon in Chicago. Amer. J. Sociol. 6: 289-306, 433-464, 1900.
3. Pryzhov, I. G. Istoriya kabakov v Rossii v svyazi s istoriyei russkovo naroda. Moscow 1868.
4. Webb, S. & B. The History of Trade Unionism. New York: Longmans Green 1920.
5. Hesse, E. Narcotics and Drug Addiction. New York: Philosophical Library 1946, p. 168. See also: Cheney, R. H. (Ed.) Coffee. New York: N.Y. University Press 1925.
6. I am indebted for this information to Dr. John Linton of the Canadian Temperance Federation.
7. Wolch, C. How Ontario Clergy Look at Alcoholism. Alcoholism Research 4 (4): 1-7, 1957.
8. The data upon which this argument was based are to be found in Statistics of Alcohol Use and Alcoholism in Canada 1871-1956. Popham, R. E. & Schmidt, W. Univ. of Toronto Press, 1958.

What We Don't Know About Alcohol Problems

*By Dr. Harold Kalant, M.D., B.Sc., Ph.D.**

Looking back on the summer course on alcohol problems, it appears that there was a rather neat breakdown of the contents of the sessions during the two weeks. The subjects dealt with in the first week were essentially aspects of the interaction between alcohol and the individual, starting off with things like pharmacology and pathology (what alcohol does to the nervous system, to the liver, etc.). Then we looked at what alcohol does to the individual's behavior, as determined by psychological tests, and then in terms of grosser measures of performance in one's everyday life. We considered problems of individual therapy, the relation of the individual patient to the therapist and so on. All of these things we might include under the general title of the relationship of the individual to alcohol. Then, during the second week, the stress was mainly on the interactions between alcohol and society — such things as the moral and religious aspects of community values and alcohol, the law, education, industry, community resources for treatment, and so on. Many of these were not only extensions of topics from the first week, but raised whole new points of discussion.

Moral Responsibility

For example, in the moral field, Father Ford began the second week with an extremely valuable distinction between what is considered an individual's moral responsibility for drunkenness, assuming he has a responsible free choice, and the situation presented by mental illness in alcoholism, in which the individual cannot make this choice. And, of course, this distinction has obvious implications for the people most actively engaged in the treatment

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of alcoholism, referring back in a sense, though not explicitly stated, to the point which Dr. Holmes had raised the previous week about the attitudes and values of the people engaged in therapy. Only by recognizing the validity of this distinction can one eliminate from the therapist's approach the idea of "reforming" someone, based on an implied censure of his behavior, as opposed to the idea of treatment based on some understanding of the difficulties which the individual encounters. It underlines the difference, in other words, between a punitive and a therapeutic approach. This, of course, also relates to the relationship between the law and those who encounter problems with alcohol — such obvious things as the relative contribution of alcoholics to the total of traffic accidents under the influence of alcohol, crimes committed in relation to alcohol or under the influence of alcohol, the chronic drunkenness offenders who fill the jails and thus pose both a legal and a social problem, and so on. Here, too, we must consider the point which Mr. Justice Kelly made about the gradual change in the interpretation of the existing law, and perhaps the point which was raised about the need for specific changes in the laws, to reflect a greater flexibility of approach, a change in emphasis of the law from the punitive to the corrective. This, of course, brings up the question that was raised about the applicability of compulsory therapy, i.e. whether therapy which is given under legal compulsion can be still interpreted as therapy rather than punishment.

Alcohol and Industry

There was discussion on the role of industry in relation to the problems of alcohol, and it was suggested that, in the view of the people in industry, too much has been made of the economic importance of alcoholic absenteeism to industry. Perhaps this is so, but there is a different point to be raised. One doesn't consider a job that takes up perhaps 50 per cent of one's waking hours as just a means of livelihood; it represents a very substantial chunk of one's total environment. Thinking in this line, it's pretty easy to see that the effects of strains and pressures in one's job, the effects of frustrations and irritations and ambitions in one's working hours,

may well have some importance in the production of an emotional environment in which alcoholism can thrive. The handling of this work environment at least poses a serious social problem. And, of course, if the economic significance of alcoholism to industry itself is not as great as has been claimed, nevertheless the economic significance to the community of loss of income from the individual's pay packet, and what this means to the family, is still a very real problem.

In relation to community resources the question was raised about the analogy between community action in relation to alcohol problems and the community campaigns for control of things like cancer or tuberculosis or other communicable diseases. Along with this, we considered the very important question of community responsibilities in education from the public health point of view, the prevention of alcoholism particularly in relation to work with teenagers or young people generally. In a way this was a very good theme to end on, because it carried back almost full cycle to Dr. Jellinek's introductory lecture on the first day, about the symbolism of alcohol — what it is that attracts people, young or old, to begin drinking in the first place, quite independently of the pharmacological or other specific effects of alcohol as a substance.

What We Learned

Well, this makes a very pretty picture on the face of it. Looking back over the program, over some of the things that were discussed, and some of the questions raised, it sounds like a nice, well-rounded picture. We can all pat each other on the back and say, "Yes, we're very broad-minded, we've considered all aspects of the problem, we've traded views", and to some extent this is right. I'm sure the hope is that an outline of a thoroughly comprehensive picture has been given of the relation of alcohol to the individual and to society. The need has been stressed repeatedly for this comprehensive picture, so that each specialist in his own field can do a more effective job in his own right, and can tie his work in more effectively with the work done by people in other specialties, for the sake of an

overall preventive and therapeutic effect. It is important to consider how this broader picture can be translated into real contacts within the community. For most people who are not directly connected with specialized alcoholism treatment centres, all of what we have been talking about reveals a need to go out and create such contacts in one's own community, the need at least to do your own "hard sell" to the other specialists that you have to deal with in various phases of activity in each individual community. It is our hope that the summer course has created some enthusiasm for this job, based both on an appreciation of the scope and size of the task and also on a recognition of the possibilities that have been indicated for more effective contributions.

What We Didn't Learn

Well, as I have said, all this makes a very pretty neat picture; but after reviewing all of the things that we hope have been discussed and learned and evaluated, I'd like to end on a sober note by talking about a few things that haven't been learned or discussed, and perhaps give a slightly more realistic balance to what the course yielded. Some of these unknowns, some of the things that were not touched upon during this course, simply reflect a lack of time. In two weeks, you can't discuss the whole problem of alcohol and expect to give the last word and detail on every possible aspect. The most we can hope to do is give perhaps a better way of looking at the problem, so that you can evaluate in better perspective your own particular relation to it. But many of these unknowns are truly unknowns, because nobody does have the answers; and it's from this latter group that I'd like to draw a few dangling loose ends that you can carry away with you for later consideration.

Role of Economic Factors

One of these loose ends is the role of economic factors. I'm not thinking of economic factors in the sense of political propaganda — we all know, I'm sure, that in the Russian view, in a communist

country, there is no problem of alcoholism because everybody's happy; all we have are some reactionary, bourgeois, capitalist backsliders. I'm thinking of the economic factors in a slightly more serious sense; things, for example, like Dr. Seeley's study which raised the question of the role of price of alcohol in relation to alcohol consumption. The gist of it was that as the real price of alcohol (the fraction of a person's earning power that he had to spend to buy his alcohol) decreased, accordingly the consumption increased, and this appeared to be accompanied by an increase in cirrhosis — the increase in cirrhosis of the liver indicating, we presume, an increase in the frequency of alcoholism in the community. In the panel discussion during the first week, Mr. Popham, Dr. Jellinek and Dr. Jacobsen dealt with patterns of alcohol use in other countries and other cultures. This sort of discussion raises the question of what role poverty in other countries may play in the use of alcohol; for example, some of the Chilean social workers have claimed that poverty and overcrowding are among the principal sources of personal and inter-personal tension which give rise to an increased use of alcohol. Add to this the fact that alcohol is cheaper than almost anything else the Chilean can drink, and you have what appears to be a very good reason for the very widespread problem of alcoholism in Chilean society.

Increased Prices: Gain vs. Loss

This sort of consideration, right or wrong, gives rise to the speculation, "If we decide that price is an important factor, shouldn't we raise the prices and see if we can decrease the consumption of alcohol and decrease the frequency of alcoholism?" Well, this sounds like a good experiment to do. It sounds like a nice sharply defined problem; there's a hypothesis, and a simple way of testing it. But then you begin to wonder, in the light of what both Father Ford and Dr. Jacobsen said, what would happen to the community at large, if you were to take away one of these chemical comforts which so many people depend upon to a greater or lesser extent, for tiding them over the inevitable frictions and frustrations and difficulties

that they have? By pricing alcohol out of easy availability to people of modest income, you might benefit the comunity by decreasing the frequency of alcoholism and cirrhosis. But what of the increase in disgruntlement and irritation and so on, on the part of the population that now uses alcohol without ill effects? How would you compare, how would you assess the relative gain against the relative loss? Who is in a position even to say how he could evaluate these things? Here's a whole question that we have to leave dangling, because until someone has a good fool-proof method of weighing the gain and the loss, and deciding what the balance is, other than one of pure statistics, you would certainly have to think twice before engaging in such a large-scale experiment.

Non-Drinking Alcoholics — A Problem?

Another question I would like to raise is "What happens to the alcoholics who stop drinking?" The idea of the follow-up study was referred to repeatedly, and the concept of substitute pathology was considered in other words, one way or another. I recall something a medical student said to me this year, in discussion after a class-room experiment on alcohol and tranquilizers. He asked, "What happens if someone does stop drinking, without too much trouble, and then it turns out that he becomes terribly disturbed emotionally, and becomes much harder to deal with than when he was drunk?" I replied that this was a rather unlikely situation and that usually if a person could stop drinking, hold a job, and so on, it was likely that his emotional disturbance was less severe than in the case of a person who couldn't stop drinking until he got individual psychotherapy. He said, "My father was an alcoholic — he was drunk most of the time, and he was irresponsible as far as his job was concerned, but at least we were happy at home; and then about ten years ago he stopped drinking. He managed to hold a job, and he brings home the pay every week, but he's absolutely impossible to live with." Well, I couldn't contradict him — after all, he knew the situation in the case of his own family, and this raised some serious questions.

We assume that by definition our objective is to treat alcoholism, to stop the excessive and damaging intake of alcohol; and undoubtedly, generally speaking, this is the objective which faces us. But doesn't this have to be qualified? Is it possible that this may not be the situation in some individual cases? For example, do we know enough about the individual psychiatric features involved to be able to say categorically that there are no cases in which alcoholism may be the lesser of the two evils? Obviously, the only answer to such a question is that we need a great deal more follow-up of what happens to people who stop drinking, and it would be very wrong indeed if one were to leave a course such as this with the idea that the end result could be taken for granted.

Significance of Mixed Addictions

Another question that was hinted at, or discussed lightly during the proceedings, particularly by Dr. Jellinek, was the question of the significance of other addictive or potentially addictive drugs. We know certainly a great deal about pharmacological actions of different types of drugs; we know some of the borderline, some of the overlap, between alcohol, tranquilizers and barbiturates; we know something about how one drug may partially substitute for another, or how one drug may enhance the effect of another. But of course, scientists are not unique in this knowledge — a great many people who use drugs already knew these things by trial and error. You all know that many alcoholics get, later on, to depend upon the combination of alcohol and barbiturates, and you all know about the prominence which has been given recently to the use of "goof balls", which are a combination of stimulant and depressive drugs.

The question comes up, "What is the significance of these mixed addictions?" Do we know for example, how many alcoholics are also dependent in part upon addiction to other drugs, either alternately or together? And do we know whether such mixtures really alter the outlook for treatment? Are we able to say with certainty what the difference is in outlook, in the hope

of cure, if a person has mixed addiction, as opposed to a single addiction to alcohol or to one other drug? Do we know what this does to his rate of deterioration, if he does deteriorate? Do we know what the physical and other effects are? Do we know in how many patients we may cure a person of dependence on alcohol, only to find that he transfers his dependence to something which is a little less obvious? This points out the tremendous need for a great deal more information on related fields, to find out that alcoholism is not a problem to be treated in isolation.

Therapy Doesn't Always Work

There's another question I'd like to ask, too. What happens in the cases where therapy doesn't work? We talked about the social factors which can contribute to drinking, the correction of which presumably help prevent or treat alcoholism. We talked about individual psychological and psychiatric factors that may require attention, again for both prevention and treatment. But there remains the fact that a very substantial number of patients, exposed to all the treatments that we consider to be important or relevant, still do not get better.

Well, what does this mean? Does it mean that one is really dealing with a different type of problem? Or does it mean that the therapeutic factors which we have talked about have not been effectively applied? Or does it mean that other unrecognized factors are playing a role that will have to be brought into the picture? Suppose you say that when social factors, group therapy, physical and medical therapy and education don't work, maybe this means simply that the individual psychiatric needs are still greater than we had realized. Well, where does this leave you? Suppose you decide that there is need of a great deal more individual psychiatric therapy than has so far been available. What happens if you look around and find that your whole community doesn't have enough psychiatrists to go around, as is very likely indeed? Suppose you find that it is frankly impossible to give all of the treatment on an individual basis that your review might

suggest was valid. What does this mean, then, in terms of community evaluation of what therapy should yield? Does it mean that you have to start thinking seriously about the possibility that makeshift treatment is better than none? That perhaps you might even have to decide that the damage done by alcoholism, in other words the disruption to the community, to holding a job, to providing the needs of life for the family, and so on, is great enough that you might deliberately have to substitute dependence upon some other drugs if an outright cure is not possible? Here again it is a question of values. How do you decide? On what basis do you decide whether it is better to concentrate on stopping all forms of dependence on drugs, and aim for an outright cure, even if it means treating one person out of ten, or one person out of a hundred, rather than give palliative therapy to 99 out of 100? Who would decide on the scale of values? And does this mean some kind of community decision, rather than individual decision?

All of these things, I think, are examples of problems that we haven't really been able to deal with here, couldn't possibly deal with here, because this would mean debating moral and other values, as well as talking of information we don't have. And you can't do that in two weeks, obviously.

What Must Be Done

What is the importance of these questions, then, in the overall picture that we hope you have ended up with after your two weeks of lectures and discussions and arguments? The only answer, obviously, that one can come up with in relation to the unanswered questions, is that they point out our tremendous need for a great deal more information, which means a great deal more research.

Research is always a discouraging word, because when you say 'research' people think about a cure for cancer, or a new type of solid fuel rocket to reach the moon, or some new electronic machine, or what-have-you. It's always thought of in terms of laboratories and highly technical investigations that no one who hasn't been brought up in the field can hope to do. This, of course,

is not the meaning of research. Research means a series of relatively easily definable steps beginning with an intelligent question, a question which has been formulated on the basis of available knowledge, and has been expressed in the simplest possible component parts; a question which indicates a lack in our knowledge which you hope to fill. Then, the term 'research' implies the availability of methods that can be used to answer the question. So, of course, you phrase your question in terms of the methods you have available, unless you are prepared to go out and develop new methods suitable for the question you would rather ask. And then it means accurate collection of results by these methods, and an unbiased evaluation of the information you've obtained. The whole process can involve an extremely simple set of methods, an extremely simple question, or it can be a very sophisticated question, requiring sophisticated methods. You fit your methods and your questions to the need that you have.

Research — A Challenge

After completing any course such as this, it is gratifying to be able to look at the fruits of one's labour, to admire the pretty picture of all we know. It is my hope in making these final remarks that you may be stimulated to think equally of the things that we don't know. Perhaps in your own activities you may be tempted to examine a few of these questions that you've been asked, and try exploring some of them with the methods that you have available, so that either you might be able to answer some of them, or you might be able to come up with enough information to stir and spur somebody else to answer them. This is always a nice pious hope to express at the end of any course, particularly if you don't have to take responsibility for initiating any of the steps involved. But there is this reason for it, namely that research is regarded to a large extent by the general public as a special function of a few specially trained people, and in the last analysis, it is not. It is a function of any informed intelligent curiosity. So with this hope, and in the knowledge that I won't have to answer any of the points raised, I'll leave this as the parting shot. ■

FOUNDATION NEWS . . .

• **Dr. G. Harold Ettinger,** former Dean of Medicine at Queen's University, joined the Foundation in October as the new Director of Medical Planning. Born in Kingston in 1896, Dr. Ettinger attended Queen's University where he received his B.A. in 1916, his M.D. and C.M. degrees in 1920. He was awarded the M.B.E. in 1946, and received an honorary D.Sc. from the University of Western Ontario in 1958.

Dr. Ettinger also became chairman of the Medical Advisory Board when **Dr. J. K. W. Ferguson** retired from that position in October.

Dr. Ferguson, who has been chairman of the Medical Advisory Board since 1955, will remain as a member of the Board. He is director of the Connaught Medical Research Laboratories.

• The new **Lakehead branch of the Foundation,** situated at 1020 Victoria Avenue, Fort William, officially opened in October. The administrative head of the new branch is **Fred Stevens,** M.S.W., a former Ottawa social worker and school teacher.

Lakehead branch was formed in response to a significant local demand. Local interest there was evident as far back as 1958 when **Dr. John D. Armstrong, Miss Margaret Cork** and **Mr. W. J. Wacko,** visited Port Arthur and Fort William to address an annual conference of public health personnel from various points in northwestern Ontario. At that time, they also met with a number of professional and community groups, including members of A.A., and out of this grew a group of vitally interested citizens who formed themselves into the **Lakehead Committee for the Study of Alcoholism.** This, in turn, led to the development of a key executive group that carried on negotiations with the Foundation in Toronto.

Prominent in the formation of the Lakehead committee were: **Dr. J. R. Augustine,** an internist with the Spence clinic;

R. R. Fox, vice-president of the Fort William Chamber of Commerce; **Alexander Phillips,** manager of the Northwestern Ontario Development Association; and **J. R. Commuzzi,** sales manager of Lakehead Motors Ltd.

Mr. Commuzzi, who is also chairman of the Port Arthur Board of Education Advisory Board, and chairman of the Board of St. Joseph's Hospital, has accepted the chairmanship of the new Lakehead branch of the Foundation. Dr. Augustine has accepted the chairmanship of the Medical Advisory Committee.

• **Miss Catherine McGuire,** a counsellor at the Alberta Alcoholism Foundation for seven years, joined the Toronto clinic of the Addiction Research Foundation in October. For the past three years, Miss McGuire, who has her M.A. in psychology was with the testing and counselling service, department of psychology of the University of Alberta. She was one of the first staff members of the Alberta Foundation when it began operations in 1953.

• A second Residential Course on Alcohol Problems is planned for the summer of 1963. It is expected that the course will be located on the campus of Queen's University, Kingston, from June 9th to June 21st. The course will again be directed towards those persons who, in their professional capacity, are concerned with problems associated with the use of beverage alcohol.

The curriculum is being planned under the guidance of a Scientific Advisory Committee comprising J. A. MacFarlane, M.B.; J. K. W. Ferguson, M.B.E., M.D.; W. E. Boothroyd, M.D.; Oswald Hall, Ph.D.; E. M. Jellinek, M.Edn., Sc.D.; and Dr. G. H. Ettinger, M.B.E., M.D.

Inquiries about the 1963 course should be addressed to Gordon M. Patrick, Assistant Director of Education, Addiction Research Foundation, 24 Harbord Street, Toronto 5, Ontario.

Addictions

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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspects of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (365-4521).

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A.A. Addictions WINTER, 1962

Industrial Physicians Need to Know What Alcohol Means to All Employees

*By J. F. S. Walmsley, M.D., D.P.H.**

All of us in industry — both management people and occupational health specialists, have a great deal to learn about alcoholism; and I feel that we, in the medical field, must give leadership in this.

First, we must understand more about ethyl alcohol, about its origins, its uses, its relationships in our society, and its special meanings in all the ethnic groups that make up our country. Unless we do this, we will become lost in our own prejudices, our own emotional reactions to alcohol.

How many of us have sat down and assessed how we personally feel about alcohol, regardless of whether or not we drink? If we do drink, why do we drink? And what is the effect of alcohol upon ourselves? If we don't drink, how do we feel about people who do? Our feelings are going to affect what we can do for people with

* Dr. Walmsley is company physician at the Canadian Kodak Company, Toronto. This article is slightly revised from a talk he gave during a panel discussion on Industrial Hygiene at the University of Toronto, in June, 1962.

problems. They will be reflected in the industrial health programs we present to management, and to the nurses who work with us in our company.

Alcohol — Its Role in Society

We have to understand a bit about the physiological effects of alcohol, its toxic effects, and the various reactions it can produce. I think this is the general knowledge that we need. I think that we then need to understand the role of alcohol in our community, and what alcohol means in the many different ethnic groups that make up our employee population. Then, there are contacts with management. They have get-togethers in which alcohol is served; here, we have the opportunity to assess their reactions and feelings towards alcohol. I think it is this kind of understanding that will help us when we are called upon to assist an employee who has a problem with alcohol.

The next thing that we need to look at is our own company's program, that is, our total occupational health program. What are our objectives? What are we trying to do? We can only have an effective program for problem drinking, from the point of view of rehabilitation, when we have an objective, meaningful, total health program. If our health program is a preventive, educational one in which we are trying to get at early cases, then we must be on the lookout for incipient alcohol problems. This is something we must always bear in mind.

Industrial Physicians Can Help

All industrial physicians know the various things we think of when we see a rash. We start getting into the signs and symptoms and making a diagnosis. I think the same applies in problem drinking, and we have to watch for it. We have a program for periodic health assessment, periodic health examinations. This could be our first source of information. There is no reason why we should not enquire about an employee's alcohol history, his attitudes towards drinking, and its effect upon him. We may not always get frank answers, but the examination plus his reactions to the questions, may tell us something. Return-to-duty examinations after an ill-

ness, especially in the case of men, may also point out reasons for the absence. The other source of information about drinking problems comes from those employees, who, on their own, begin to feel that they may have a problem and come in to see us.

To be successful in treating the industrial employee with an alcohol problem, the health program must be employee-based, it must be confidential, and it must be understood and accepted by both the employee group and management. If one has this type of total health program under way, then it is much easier to set up a program for rehabilitating the employee who is a problem drinker. To do this, however, we need to define our terms — just what are the problems created by the employee's excessive drinking; and we need to define a program and have it accepted by management.

This program should be based upon recognition that alcoholism is a disease and that an employee can be rehabilitated. If required, I also think that an employee should be treated at an outside centre, such as the Addiction Research Foundation Clinic, or Dr. Bell's Clinic, or other sources of therapy which offer daily treatment; or admitted to hospital. The patient should also qualify for sickness disability benefits during that term.

A Chance at Rehabilitation

Thirdly, I feel that after such a treatment procedure, the patient should be given a real chance at rehabilitation. Both he and management should understand that this is only the beginning, that he may have relapses, and that he may get into trouble. But he should not be dismissed until a real effort has been made. It is vital that both management and the employee understand about relapses. They should know that often, in spite of relapses, the alcoholic can be rehabilitated and will prove useful on the job. I know cases in which such an employee took a drink on Saturday night, and on Sunday morning realized he could not keep his drinking to one or two bottles of beer. He was back at work on Monday morning ,and even told his boss about the problem. He also discussed it with us in the medical department. He was learning, and this is the important thing. ■

Jail is Often Better Than Life Outside For The Chronic Drunkenness Offender

*By P. J. Giffen, M.A.**

In Toronto and in most large communities in North America, you can find a considerable group of men who are in and out of jail repeatedly for public drunkenness. Last year, some 18,000 cases were heard in Toronto's Court "G", the Magistrate's Court which handles public drunkenness cases that occur within the city limits. These appearances were accounted for by some 10,970 individuals, of whom 3,000 were there twice or more and some of whom appeared more than ten times in the year. We know that once a man has entered the revolving door, he may continue in it for decades, and actually serve hundreds of jail sentences.

It is also known that the statistical probability of a man's emerging from the revolving door is very small. Treatment facilities such as the Harbour Light Mission, the Alex G. Brown Memorial Clinic, A.A. and the Addiction Research Foundation Clinic only manage to salvage a few from a relatively large population. Although we don't know exactly how many of these men there are in Ontario, 5,000 individuals is probably a conservative estimate.

The remarks that follow will have to do with some of the sociological characteristics of this population as observed in a large urban centre. The situation in smaller communities may differ considerably. The problem is aggravated in a city like Toronto by the existence of a well-developed system of hostels, missions and other facilities for homeless men, so that it tends to become a mecca for men of this type from smaller communities and other parts of Canada. We have found that no more than 20 per cent of the chronic drunkenness offenders in Toronto grew up in the city. A large number come from other places than Ontario and some-

* Mr. Giffen, an associate professor of sociology at the University of Toronto, is directing the Attorney-General's special project studying chronic drunkenness offenders. This article is slightly revised from a lecture he gave at the Summer Course on Alcohol Problems, sponsored by the Addiction Research Foundation at the University of Toronto, in June, 1962.

where between 20 and 30 per cent from the Atlantic Provinces. Once a chronic drunk finds his way to Toronto's Skid Row, he is likely to stay.

Few Alcoholics Hit Skid Row

Three characteristics of this group deserve special mention. The first is the fact that they differ from the majority of alcoholics in our society in their vulnerability to arrest. Estimates of the proportion of the alcoholics in our society who are involved in the revolving door vary from three per cent to 12 per cent. Secondly, most of these men are alienated from conventional social relationships and memberships to a striking degree — the term "undersocialization" is sometimes used to refer to this phenomenon. Thirdly, they are participants in what we can call a deviant social system; they are the drinking segment within the Skid Row society.

Arrest and Incarceration

In our society it is regarded as offensive, if not dangerous, to allow people to stagger around the streets drunk or lie stretched out in doorways. Both the law and public opinion create the expectation that the police will "keep the streets clean". The offence is not simply being intoxicated but being intoxicated in a public place, which means that men who have no home in which to drink, or no family or employers to protect them are more likely to be in the streets and are thus more likely to be arrested. The more often they are arrested, the less likely they are to have access to a private place in which to do their drinking. Moreover, they are more likely to appear in a highly policed downtown area and to be highly visible because they are ill-dressed and unkempt.

Although the law was changed in 1961 to do away with the mandatory jail term for repeaters, the net effect was still very much the same. The majority of chronic offenders are unable to pay a fine of any magnitude, so they must serve the alternative jail sentence in any event. Many of them continue to spend more time in jail than they do outside. The threat of imprisonment obviously serves little or no deterrent function for men of this type, since they have a higher rate of recidivism than any other type of offender.

The policies of the police play an important role in determining who enters this population and how rapidly the revolving door goes around. In some places, the police follow a policy of containment, as they do on New York's Bowery, where men tend to be left alone as long as they confine their activities to that area. The police in Toronto are believed by Skid Row men to be unusually zealous. Our own observations are that even in Toronto, only a small percentage of the people who are drunk in the downtown area on weekends are picked up. If an intoxicated person looks as if he can get home under his own steam, and is unlikely to come to any harm, he may not be arrested. The chonic drunkenness offender, even if he is not known to the police, appears to be a man who likely has no home to go to and will end up sleeping where he falls. The decision of the police to arrest is, in effect, an adjudication of guilt, because drunkenness offenders almost invariably plead guilty when they appear in court. The empirical probability of a case being dismissed in the drunk court in Toronto is one in 500.

The high probability of arrest in Toronto, and of going to jail once arrested, helps to perpetuate this way of life. It shortens sprees and means that the men spend a large part of their time in jail where they have no liquor, but do have a healthy diet and regular hours. Thus, they are, in some degree, protected from the more severe physical consequences of prolonged drinking. This also means that they do not have to worry about the consequences of going on an almost constant binge when they are out of jail and of eating little or nothing, because they know that they will soon be back inside.

Become "Socialized" to Jail

The frequent jailing of these men seems to have a cumulative effect. They become accustomed or "socialized" to the jail society, so that if it ever had a strong deterrent effect, it wears off over time. They learn to adjust to jail with the minimum of distress, to do "easy time". A man may even acquire a right to a certain job within the jail which he will perform each time he returns. The job may carry with it a certain amount of recognition and minor

privileges, in contrast to his low status and anonymity in the larger society.

From the viewpoint of the authorities in the large urban jail, most chronic drunkenness offenders are good prisoners. They are tractable, uninterested in escaping, and reliable workers. Their occupational reliability within the jail is something of a paradox, since most of them seem to be uninterested in working outside of jail. In general, the jail staff are likely to have a more favourable view of drunks than the other authorities, and to treat them accordingly. The police see them drunk and obstreperous, the courts see them in a deferential role and probably in a poor state because of their drinking bout, and the operators of Skid Row facilities see them as a particularly troublesome element within the population of homeless men.

Many of the chronic drunkenness offenders have had earlier experiences that have prepared them for living in an all-male institutional setting. Quite a few of them have previously been in lumber camps, railroad gangs, the merchant marine, and the armed services, and few of them have become accustomed to, or dependent on, domestic life. A considerable number have had experience in reformatories and penitentiaries at an early age. In all these settings, they tend to be under authority and have few decisions to make for themselves, so it is not difficult for them to become acclimatized to jail life.

Some Men Prefer Jail Life

This does not mean that the men will admit that they like jail; such an admission seems to threaten their self-respect. But they are much less critical of the jail staff than of any other authorities with whom they are in contact, and they will admit that there are many other men who are "crashers" — men who deliberately expose themselves to arrest in order to get into jail.

When the punishment aspect of jail is assessed we have to think in terms of relative deprivation. For a middle-class person, being in jail is a pretty catastrophic experience, since he is cut off from his family, his job, his friends and is socially stigmatized. When we

compare jail life to the life outside for the Skid Row man, we realize that the painful consequences are relatively much lighter. He is already stigmatized since he is at the bottom of the social scale, and his conditions of life outside tend to be chaotic and uncomfortable. He sleeps in missions, doorways, boxcars, or, occasionally, rented rooms, and when he eats, if he eats at all, the meals are usually of a poor quality. When these men describe their daily round when they are drunk, there is something of a nightmare quality. Jail is not, in relative terms, a bad place.

It is particularly significant that when these men are in jail, very few of them, according to their testimony, feel a craving for alcohol, except during the initial period when they are suffering from withdrawal. They say that they do not think much about drinking as long as they are in jail. Much of the energy and ingenuity that went into finding alcohol on the outside, is directed toward getting cigarettes, special food, and other minor privileges in the jail. Many of them are talented manipulators within their familiar and circumscribed settings.

Alienation from Normal Society

By the time these men are in the revolving door, most of them are cut off from the main relationships and satisfactions that we regard as important. Many of them have never married, and those who have are separated or divorced from their wives. Those who have relatives, children, or friends from more respectable days, tend to avoid them. They have little or no contact with women, and no stable occupational affiliations since they work only at casual labour. In short, they are to an exceptional degree isolated from the relational rewards of normal living.

Skid Row Drinking Society

At the same time, the men on Skid Row who drink heavily have a substitute, however unsatisfactory, in the company of men like themselves. They usually have a large number of acquaintances in the same boat, men they have met when drinking, in jail, in parks, in hostels and so on. This group is deviant because its code

of behaviour differs from accepted standards. The group norms are focussed on getting alcohol, arranging for others to share the drinking of it, and avoiding arrest. A surprisingly large amount of the drinking is social. A man may take his first drink of the day alone, particularly if he is "sick", but he will then seek companionship for his drinking, and might even postpone his drinking for a considerable time until he rounds up company. There are strong norms of reciprocity and an etiquette of drinking with which all the participants are familiar.

It is a highly specialized and unstable sub-culture. The "bottle" groups are loose formations. In a single day, one man may pass through several groups. The groups are always in a state of flux and movement, and there are no recriminations if a man moves from one group to another, and no questions are asked if he suddenly appears to join one. They tend to avoid highly aggressive people who will get them into trouble, and they resent "boomers", that is, those who take more than their share of the bottle, and men who in other ways fail to reciprocate. But the sanctions are few, and memories are short.

Although the men constantly denigrate their surroundings and their companions when talking to interviewers, this is all they have. Their deviance is rewarded by social acceptance and the company of equals shields them from slights, criticisms, and rejection. However, their dependence on Skid Row companions increases the cost of going straight. Not infrequently, they make sporadic attempts to give up drinking but they usually return to their Skid Row friends when isolation becomes unbearable.

Can They Be Rehabilitated?

One of the virtues of half-way houses for men of this type is that they try to provide the solidarity and mutual dependence of Skid Row life, but at the same time change group norms so that attempts to stay dry and hold a steady job are supported and rewarded. Most of the welfare institutions of Skid Row unwittingly help to perpetuate the revolving door pattern since they help the men to meet their minimum physical needs without working, and

without providing any effective means of motivating them or fitting them to break away from Skid Row.

However, it is probably misleading to think of rehabilitation of these men according to middle-class standards. Given their age and lack of occupational and social skills, it is unrealistic to expect that many of them will be able to create for themselves an independent role in the community that includes a regular job, a home, a family and a circle of friends. Experience elsewhere seems to show that for many of these men some form of sheltered living is inevitable. The challenge is to devise a system that will enable them to be more productive, less dependent on heavy drinking, and more interested in other things than they are when caught in the revolving door. Studies of chronic drunkenness offenders also point to the importance of attempting to rehabilitate these men at an earlier stage when they are younger and less alienated. ■

Narcotic Addiction: Some Thoughts on Present Programs and Future Needs

*by S. J. Holmes, M.D., D.Psych.**

The problem of narcotics and narcotic addiction is a world-wide situation that involves many countries to varying degrees, from varied points of view, for example from production, export, manufacture, trafficking and addiction, and with many varied socio-cultural influences.

Narcotic addiction in Canada, in terms of numbers, is small when compared, for example, with that in the United States. However, when it is viewed as a part of a total social disorder, then

* Dr. Holmes has had considerable experience with drug addiction, serving as consultant to the Drug Addiction Clinic at Mimico Reformatory from its inception in 1957 until June, 1962. An expert in alcoholism as well, Dr. Holmes has worked with the Addiction Research Foundation in Toronto since 1950; the Alex G. Brown Memorial Clinic from 1957 to 1962; and Shadowbrook and the Bell Clinic from 1948 until 1956. In addition to his private practice in Toronto, he is a clinical teacher in psychiatry at the University of Toronto. Dr. Holmes has also worked with the Department of Veterans Affairs at Sunnybrook Hospital since 1947.

it takes its place proportionately with other chemical relationships or deviant behavior patterns. Over the past seven or eight years, there has been very little change in the total narcotic addict population as reported by the Narcotic Control Branch of the Department of National Health and Welfare. In 1961, there was a total of 3,395 addicts in Canada known to the Narcotic Control Branch, and these are divided into 3,048 criminal, 224 medical and 123 professional addicts.

It would appear that there has been a gradual reduction over the years in the medical and professional addicts with a corresponding rise in the criminal addict group. It has been estimated by the Addiction Research Foundation of Ontario that there is one narcotic addict to eight non-narcotic addicts to every 100 alcoholics. In Canada, the narcotic addict population is found related to three centres, namely Vancouver, Toronto and Montreal, with appropriate figures of 1,872, 913, and 316 addicts in the order of the city mentioned. These figures must be accepted as minimal and only by further epidemiological studies will we arrive at a more realistic numerical, geographical and social picture.

Ambivalent Approach

The approach to the problem in Canada at the present time shows considerable ambivalence but does not appear to be influenced as militantly by punitive thinkers as appears to be the present attitude in the United States as compared to the more humane orientation in Great Britain. While it is true, and indeed often quoted to varied interpretations, that the laws in Great Britain, United States and Canada with regard to narcotic control are not basically different, this really is only part of the story. While there is no definite "British System" of handling the narcotics addict, there is nevertheless a difference in fundamental philosophy between the medical and legal experts in Great Britain and that to be found on the continent of North America.

In Great Britain when they say that narcotic addiction is a medical disease, they mean just that and leave the treatment decisions, both short-term and long-range, strictly in the hands of the

medical doctor. The legal people maintain an interested — but in the main a hands-off policy — on such registered addicts undergoing therapy.

Recently, a change has become evident in the attitude of the Canadian public towards people who develop addiction. We are showing more understanding and tolerance of the addict, and there is almost a popular demand for treatment facilities for all addictions. Our views on handling the problem are becoming more medically oriented, and fewer people are inclined to think only of penal servitude facilities for the treatment of narcotic addiction.

Important Changes

In 1961 two major events occurred from a Canadian point of view. The first was Canada's leadership in the Single Convention on Narcotic Drugs aimed at International Control. (For further details of this I would refer you to Mr. Curran's excellent article in the November, 1961 issue of *Medical Services Journal of Canada* — Volume 17, Number 10, as well as Mr. Macdonald's article in *Current Law and Social Problems 1960 and 1961*.) The second was an enactment by the Parliament of Canada of a bill, known as the Narcotic Control Act, which was introduced by the Minister of Justice in cooperation with the Minister of National Health and Welfare. This new act replaces the Opium and Narcotic Drug Act which had been in force since 1919.

In this new act, a number of important changes in the previous system of control and enforcement have been made. These have been designed to permit the legislation to be more effective in achieving two purposes: (1) to facilitate the availability of narcotic drugs for medical and scientific use; and (2) for the effective supervision of the illicit narcotic traffic. Added to the latter, this new bill contains a new provision and procedure relative to the treatment of narcotic addicts which is thought to offer, for the first time, a realistic and humane approach to this problem.

The Narcotic Control Act became law September 15, 1961, but the treatment proviso is not effective until treatment facilities are organized. At present, the first of what may be three 450 bed

units is under construction in the interior of British Columbia, and its possible opening date is early 1963. I understand there are plans in the future for a similar unit in the Toronto and Montreal areas.

Proposed Treatment of Addicts

In the new legislation, a person convicted of an offense under the Act and diagnosed prior to trial as an addict, may, on the first offense, be sentenced to treatment for an indefinite period up to seven years, and on a second offense, be placed under treatment supervision for what could be the rest of his or her life. In accordance with the penitentiaries system, the government has indicated that special facilities or institutions as mentioned before, will be set up for the reception and accommodation of addicts who are so sentenced. These persons will be given such treatment as experience may indicate is required, released on parole and subject to statutory supervision for an indeterminate period. If they relapse they can be returned for further custody and treatment.

It would appear that the experience of the United States with a similar program but without a follow-up parole period at the Lexington and Fort Worth hospitals has been very disappointing. A relapse rate of some 90 per cent has been reported, which is much the same as the experience to date that I have seen in my experience up to May, 1962, at the Drug Addiction Clinic operated since 1956 by the Ontario Department of Reform Institutions at Mimico Reformatory. To date we have seen about 300 male addicts there during the last three months or so of their sentence. One of the main stumbling blocks in the rehabilitation of these patients has been the lack of parole, as well as community facilities to which the patient can be referred. It is my opinion, at the risk of being classified as a pseudo-expert, that this type of institution has a very limited use from a treatment as well as a research point of view.

The Community Clinic

Much more vital in the treatment of this addiction is the community clinic located in the cities where the addict has been living

and where the various social, family, legal and medical factors can be integrated in a more realistic and appropriate manner. This is far more promising than transporting the patient, under sentence, to a remote treatment area from which he will later be discharged to a community — either the one whence he came or one where the incidence of addiction is predicted to be low and therefore "safer" but without any real facilities for his needs. In this way, it would seem to me there is a great need for the getting together of persons of experience and interest from the fields of legal, social and medical science to develop a more balanced approach to this many-sided problem.

Addiction — A Crime or A Disease?

To date, there has been a tendency for people of experience or interest in this question to become proponents of this or of that point of view. Consequently, there is little agreement, and people often become committed to a particular point of view which really indicates their ignorance of the total problem. As yet, it would seem to me that there is much conflict as to whether narcotic addiction is a crime or a disease — or a little of both, depending on whether we are dealing with professional, medical or so-called criminal addicts. The classical example of this appears to be the conflict in the United States between the Narcotics Bureau and the joint American Medical Association and American Bar Association Committee. The former looks upon narcotic addiction as a crime; the latter regards it as a disease. As yet, the problem is unresolved.

In Canada there would appear to be more acceptance of the disease concept among many interested people, but there continues to be a variance in police, legal and medical areas about policies with regard to dealing with this problem. Thus at the present time, it would appear that the "problem of narcotic addiction" is disproportionately greater than the number of people it involves as addicts.

The reasons for this would appear to be:

(1) The tremendous impact which the narcotic drugs have on

the human organism psychologically and physiologically; and the interest this creates in all those who are, for scientific, artistic or pathological reasons, concerned with exceptional states of mind.

(2) The challenge which this phenomenon constitutes for the middle class North American value system; and the socio-legal situation which this challenge has created on this continent.

(3) The challenge which it constitutes for science, especially for the medical and social sciences and allied professional disciplines.

(4) The struggle for control of the narcotic field between law enforcement, scientific, political and social groups, and the underworld and their very different interests, which, at present, immobilizes effective social action.

Principles to Consider

In addition to the federal institutions it would appear, as mentioned before, that both research and treatment units should be established in cities where narcotic addicts are found in substantial numbers. In this, the following principles should be considered:

(1) The narcotic addiction problem has to be solved, or at least a beginning has to be made, in a given social (medico-legal) atmosphere. The vested interests and particular views of those already involved in the problem have to be understood and evaluated. In this it is most desirable to avoid taking sides in the existing ideological controversy about addiction.

(2) The narcotic addiction problem is as yet not sufficiently explored, especially as a many-sided problem, from the point of view of the total personality of the addict, and as a total social phenomenon. At least part of the research should be focussed on treatment methods, taking into consideration all the relevant aspects of the problem as an interacting system — pharmacological, psychiatric, legal and sociological.

(3) There is no existing treatment method which is at present an unqualified success. Thus, a great deal of social, medical and psychiatric inventiveness and an experimental attitude is needed in this area.

(4) The whole effort should be made in such a way that research and treatment would continuously have a bearing on each other. The different treatment experiments should be continuously evaluated and modified.

Existing Treatment Approaches

The present existing approaches to treatment could be put into four categories:

(1) *Punitive* — This approach is reflected in severe mandatory sentences, vigorous law enforcement and "cold turkey" treatment — this is a most inhuman treatment in the light of present knowledge. Sadly, I must report that in Canada this still remains the approach most commonly used.

(2) *Correctional* — This involves probation and parole and within this framework different schemes like the experiment of the New York parole department, which concentrates on working with families; the Oakland experiment, which is a combination of probation with nalline tests; and the present Canadian thinking of long sentences with early release on parole.

(3) *Hospitalization* — This medical - psycho - social treatment used exclusively in closed institutions like Lexington, Fort Worth, New York's Riverside Hospital, Oakalla and the D. A. Clinic at Mimico, is limited because it includes no organized after-care program. Somewhat similar are those programs of voluntary or committal forms of treatment in mental hospitals under the Provincial Mental Health Act.

(4) *Ambulatory-Medical* — This approach is strongly attacked in some of its forms on this continent. The accepted form is that of the Narcotic Addict Foundation of British Columbia, where withdrawal and follow-up, through relapses if necessary, is done with the option of the clinic to insist on the patient's taking Lorfan as a test for the presence of narcotics when indicated. In this type of approach, it seems to me we are unthinkingly following the treatment pattern used in instances of alcohol and other non-narcotic drug addictions as if they were similar when, in fact, there

is a great difference psychologically, socially, physiologically and legally.

Lady Frankau's Results

The type of treatment clinic unaccepted on this continent at present is that reported by Lady Frankau in England. There, the patient is stabilized and carried on a daily dose of narcotics during a period of social and occupational rehabilitation, with the eventual goal of carrying him on into drug-free relationships. The results of this experiment, as published in The Lancet in December 1960, cover a group of 51 patients treated between August, 1958 and March, 1960. There were nine medical, six non-criminal, 36 criminal types with all clear in the medical group; three clear, two on small doses intending to stop and the sixth apparently unlikely to stop in the non-criminal group; and of the larger group of 36, 20 are clear, 10 still under treatment and six have proved resistant. This type of approach is most refreshing and interesting with almost unbelievable results.

(5) *Voluntary Non-Medical* — This kind of approach is found in Narcotics Anonymous and Synanon Foundation in Santa Moncia, California. The reports from the latter groups are rather encouraging.

Probably the most difficult problem is the question of coercion versus voluntary treatment. At the present time, it appears to be the opinion of the most responsible writers on the subject in North America that in the present social context, some coercion is desirable. This may prove to be valuable in getting the patient to face treatment earlier in the disease. However, further treatment plans should attempt to explore the possibilities in the cultural setting of all the voluntary medical and non-medical approaches, or possible combinations of these, for the greatest potential in rehabilitation of the addict. From the point of view of withdrawal, it would appear that we have worked out a satisfactory method which can be practised in a closed hospital setting, under medical supervision, with a minimum of discomfort and complication. In my opinion, every addict is entitled to such a humane withdrawal but this is still not done in many instances.

Most important, however, in the treatment of the addict is rehabilitation. In view of the psychological and social factors related to the addiction it is necessary that exploration of these start as soon as the addict enters a treatment situation. Rehabilitation includes:

(1) *Vocational guidance and training or retraining* for new occupations since a large percentage of addicts have never developed an adequate work pattern. Many experts point with emphasis to the fact that 90 - 95 per cent of the criminal group have shown criminal behavior prior to addiction which, in their opinion, practically closes the door to therapy — at least in these experts' minds. We must recognize, however, from the work of Sturrup in Denmark, that much can be attained in the rehabilitation of severe psychopathic personality disorders.

(2) *Supportive social therapy* — most addicts have inadequate recreational and social life. There should be a diversified program to include sports, motion pictures, dancing, reading and other indoor games, with special emphasis on ego development in interpersonal relationships, with both sexes participating.

(3) *Individual psychotherapy* — where indicated, this should be aimed at the patient's personality needs.

(4) *Spiritual therapy* — with pastoral counselling this may lead to acceptable human relationships and to a philosophy that can be applied further in North American relationships and beyond in social integration.

(5) *Group therapy* in which there is mutual discussion of emotional problems and social participation with other patients, is used in order to fulfil the needs of the poorly motivated patient.

A full follow-up with inclusion of the patient and other members of his family, where necessary, is essential in therapy.

The Addict and His Family

In the management of the addict and his family, it is necessary to study the patient in this milieu as a whole from the point of

view of the heredity and constitutional factors, the development of the personality, and its reactions to the environment. Analysis of the patients' reactions, and the dynamic factors involved, helps them to achieve the ability to deal with anxieties, to understand and accept these limitations, and to tolerate emotions which arise from frustration. Insight is not enough. They must try to control and strengthen personality weaknesses, for security must be based on self-reliance combined with the ability to become an integrated member of society.

In this approach, the attitudes of both the patient and the members of the treatment team play a most important role. The fact that the attitude of many addicts may be pretty negative toward life without drugs, and the fact that the relapse rate is very high, should be expected and accepted rather than looked on with disdain or with criticism of the patient. We cannot realistically ask that the addict never use drugs again; but we can ask and expect him to go to work and in this way build a new pattern of living.

Most addicts are quite ambivalent in their desires with regard to drugs. They have a desire to stop using, which was remarked on in terms of its high frequency, in a recent Canadian Medical Association Journal article by Martin and Dancey. We can strengthen this desire by acceptance and understanding at all times, whether initially or during relapse, and in this way put the onus for his behavior on him. Present attitudes of rejection, punishment, kicking his habit "cold turkey", all help the addict to expiate his guilt feelings and make relapse more acceptable to him, as well as a return to the acceptance he finds in his sub-culture of drug addicts down at the "corner".

Prevention and Education

From the point of view of prevention, a program of appropriate education with regard to drugs of all kinds should begin at the school level, including both the medical school and the grade school. While the large proportion of narcotic addicts have poor school records, they are curious and read a lot. Many have said they might

not have been overcome with curiosity at the tales about drugs if they had known more about them in the first place.

We must develop a sound approach to the problem of juvenile delinquency, of which drug addiction is only a facet along with alcoholism, criminal and other anti-social behavior. In the light of our present knowledge, the commonest and most disastrous conditions leading to delinquency are those centered about the family life. In this, the potential delinquent is one who at some stage of his development has been blocked in his needs for a satisfying relationship in the family. Unfortunately, emphasis is still placed on protecting society and not in the fuller development of individuals who show early signs of not becoming integrated satisfactorily. It is my concept that a comprehensive treatment and rehabilitation unit for narcotics addicts must be centered in, and have a close relationship with, all aspects of community life. It is in the community that addiction begins, and it is there that it must be treated and prevented.

The Problem of Contagion

Another factor in prevention is from the point of view of contagion. It has been accepted that this illness is spread from an addict to the potential addict through identification, curiosity, daring, the need to be accepted, to belong and so on. This assures status for the addict as well as a supply of drugs. It has been proposed that clinics where the addict is maintained on drugs reduces his need to be at the corners where others can relate to him, and to the black market, thus reducing the development of new addicts as well as reducing illicit trade. Such reports have been coming from Britain, where the addict can get his drugs when necessary from doctors, and although these theories have been attacked by American writers, they would certainly bear some consideration.

Much Research Needed

A very great emphasis must be placed on the need for further research in the field of narcotic addiction — psycho-social, bio-

chemical and physiological. There is much need for study of the natural history of addiction in individual addicts, with attention to both the social and personal factors related to the development of the disorder. The social factors in the epidemiology also need further study. Evaluation studies must be built into all treatment and rehabilitation programs, especially in evaluating the many contradictions which have developed in various areas with regard to statistics, and methods of treatment, types of patients, agencies best suited for referral, and so on.

In conclusion, a program for control of narcotic addiction requires a determined enforcement of laws against distribution, possession and sale by non-addicts. This should be accompanied by a co-ordinated program in which there are a number of closely integrated elements, ranging from a penal setting through to a program of intensive and continued after-care in the community. Throughout, emphasis should be placed on the experimental pilot character, with intended diversification of interest and emphasis of these programs at this stage, and of the very great need for epidemiological research and well designed evaluation studies so that we may have some idea of what we are doing and how effective we are being. Our choice of approach should be our own, patterned on what we can learn from American, British and other European approaches, but comprised of the fact that our culture is not directly identified with any of these patterns.

Must Be Objective

Let us refrain from reacting to public anxiety, political crises, and legal pressures relative to the lack of knowledge of dealing effectively with the narcotic problem and thus be precipitated into unfortunate experiments such as have occurred in the past. Rather, let us maintain an open mind and sift the evidence as it develops, in an objective manner that will enable us to progress in a responsible and reasonable way, over the long term studies of the life history of the addicts and the cycle of addiction. ■

The Ethics of Treatment

*By Imre Nemeth**

In the 1962 summer issue of "The Humanist", Dr. Nathaniel S. Lehrman wrote an article in which he offers criticism of some of the present practices and attitudes in the mental health field. He begins by quoting Marie Jahoda to the effect that "one value in American culture compatible with most approaches to a definition of positive mental health appears to be this — an individual should be able to stand on his own two feet without making undue demands or impositions on others."[1] He distinguishes between organized activity against mental illness and the fostering of mental health itself. Then later, he comments "in view of the uncritical, almost reverent acceptance of these ideas and practices, they should be examined. Two moral questions seem of special significance. Does mental health sometimes tend to see man as more devoted to himself than to being his brother's keeper? Has mental health somehow helped inhibit the right freely to inquire?"

Dr. Lehrman charges that "in health the directions of physicians are usually taken on faith and the same is true in relation to mental health." Further, he says, some patients seem to be "harmed by previous psychotherapeutic contact." He describes a case where a marriage broke up because of the psychoanalyst's refusal to see the wife of the patient and accept her as well as the marriage as relevant to the treatment situation. He concludes that "moral neutrality is a rather important part of the mental health ideology."

Psychiatrists — Today's Clergymen?

"The psychiatrist," Dr. Lehrman goes on, "has acquired a rather awesome quality to many people. To them, he has become the unquestioned expert on what goes on within their own minds. In many ways, the psychiatrist of today fulfills the functions of the clergyman of yesterday. The moral laws under which psychiatrists actually seem to operate may determine the probable direction of

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the mental health movement itself." But, "although clergymen have recognized and grappled with moral and social conflicts throughout the years, psychiatrists and other mental health professionals tend to avoid them. Their primary orientation is towards reduction of pain, but as we have seen, this reduction of pain can appear without regard for either ethical consideration or the rights of others."

"The idea that laws and man are eternally in conflict, and that codes are therefore followed primarily because of fear, is scientifically unsound. The importance of adherence to moral codes from positive devotion is underestimated by both psychiatry and the mental health movement," Dr. Lehrman says. "The moral anarchy so pervasive in the mental health approach is frequently aggravated by its rather destructive attitude toward ideals and effort, toward thinking and heroism. The net effect of all these denigrating psychological studies is to deny that good really exists and to imply that individual freedom from anxiety, rather than social usefulness with its accompanying stresses, should be the prime purpose of living."

Mental Health and Education

At the end of his article, Dr. Lehrman quotes the Group for the Advancement of Psychiatry regarding mental health education: "There is no conclusive evidence, they assert, that it prevents mental disorders or promotes mental health. Nor is there established evidence that it does not. However, the public belief that education for mental health is of value results in extensive public education efforts."

Dr. Lehrman concludes, "If these issues are confronted squarely, they can doubtlessly be solved. If they are not, however, mental health might run the risk of becoming a scientific-seeming moral fraud. Such an outcome in the present age of anxiety would hardly benefit either our country or mankind."

Ethics and the Tyranny of Experts

The criticisms which Dr. Lehrman directs against the mental health field and psychiatry in particular have to be seen in a proper

context. Problems about ethical neutrality and the tyranny of experts are not peculiar to psychiatry alone but apply to our society as a whole. However, some professions are more exposed to them than others.

There are four general points which are important to remember.

First — that the whole Western world is in a "moral vacuum", since, to use Maslow's phrase,[2] neither religion nor the different ideas derived from the Enlightment have universal significance any more and the consequence is the prevalent moral relativism and pluralism.

Second, as Tawney pointed out, there is a characteristic Anglo-Saxon reluctance "to test the quality of an activity by reference to principles" and "to take fundamentals for granted."[3]

Third — that science, especially under the influence of positivism, has banished values from the realm of serious thought.

Fourth — that the most influential men who have shaped our attitudes in the social sciences, men like Max Weber and Sigmund Freud, were either advocating moral neutrality *as a method of inquiry*, or denying that morality is a problem for the clinician. Their followers took this as encouragement to give up concern for morals as unscientific.

The Problem of Morality

All these tendencies and attitudes are present to some extent on this continent, but there is an unusually strong concentration of them among the helping professions and the mental health movement. This situation presents several problems which could be summarized in the following points:

1. It is quite impossible to return to "old-fashioned" values (and I include as old-fashioned all the current ideas which have their root in the 19th century or before: Christianity, capitalism, liberalism and Marxism). These value systems no longer answer the questions which our age presents, although some of their basic ideas still have qualified validity.

2. The moral neutrality of science does not eliminate value judgments. As Professor Burtt put it, "value-free science has meant simply that the values dominating our thinking have retired to the arena of our underlying presuppositions."[4]

3. In a field like mental health, where certitude is rare and knowledge is cumulative, it is nearly impossible to be efficient without some basic convictions.

Alcoholism and Mental Health

How is this relevant to the field of alcoholism treatment? It is an accepted axiom among us that alcoholism is an illness, not a sinful indulgence due to weak will. This central axiom is supported by a multitude of satellite ideas, for example, that alcoholism is nearly always associated with emotional illness; that psychotherapy is an effective method in curing the alcoholic; that permissiveness, self-determination, a sense of confidence are essential in the treatment effort, and so on.

Obviously, the ethical systems implicit in this controversy are the Protestant ethic versus the Rationalistic ethic. Science is assumed to support the latter, although this is often debatable. If we continue to believe in reason, qualified by the same sort of occasional doubt and uneasiness as that of the last great social thinkers of the 19th century, then we have no choice but to assert this faith, seek support in facts and refrain from being dogmatic.

Dr. Lehrman's critique is valid, necessary and fortunately not isolated. There is a whole movement in the mental health field — Maslow calls it "the third force in psychology"[5] — which raises just these questions. But raising the questions and exposing the mistakes of others is just the first step. At present we have no scientific basis for values, and it is not at all sure that science is the best source of values anyway. We are not very much farther along than Max Weber when he was holding that our initial values come from our individual experience and we have to labour to make them as rational as possible. In therapy, this means awareness of our own

values, the patients' values, the common values of a given segment of society, rather than moral neutrality.

The Question of Values

Some thinkers, notably the European Existentialists and their more optimistic American pupils, gave a lot of thought to the question of values. Authenticity, decision, courage, the I and Thou relationship, care, engagement and commitment, are new formulations of values which are promising. Unfortunately, they are still very much investigated only on the individual and interpersonal level. The value problems of society are not solved.

There is a new trend in psychiatry — in social work it always existed — to look beyond the individual sufferer and see him in a social context. Ingenious methods of family therapy, group therapy and community therapy are elaborated. Again, we have no evidence that these methods are effective. As always in therapy we start from hunches and the faith that we are doing something worthwhile. We are as Foulkes and Anthony pointed out, "set between the proverbial horns. Too much science will kill therapy, too little science will reduce it to the status of faith healing."[6] Thus we must proceed from vagueness toward precision, from observation to accumulation of knowledge. Only in this way can we make sure that our therapeutic activities will enrich the historical experience of the mental health field.

Max Weber himself declared that "an attitude of moral indifference has no connection with scientific objectivity",[7] as he attempted to transcend the mistakes of both positivism and idealism.

Certainly a diffuse and impatient humanism and arbitrary simplification of issues will not help. Questions of values pertain to the whole man in all aspects of his life as an end in himself, as well as a part of humanity, and the forging of a new ethical system will require hardheaded reasoning. But it will also require the attitude which existentialism emphasizes: we cannot comprehend man, we cannot understand the human situation unless we approach it with sympathy and compassion.

The mental health professions should draw on the classical values of Western humanism and translate them into a contemporary code of morality, into a "new scientific humanism." It is not at all necessary either to evade the problem of ethics or to mystify our patients by the magic of expertise. ■

REFERENCES

1. Jahoda, Marie, Current Concepts of Mental Health. New York, Basic Books, 1958.
2. Maslow, Abraham, Toward a Psychology of Being. Princeton, Van Nostrand, 1962.
3. Tawney, R. H., The Acquisitive Society. London, Fontana, 1961 (Org. Pub. 1921).
4. Burtt, E. A., "The Value Presuppositions of Science", in Obler, P. C. and H. A. Estrin, The New Scientist. New York, Doubleday, 1962.
5. Maslow, A., Op. Cit.
6. Foulkes, S. A. and E. S. Anthony, Group Psychotherapy. Harmondsworth, Penguin, 1957.
7. Quoted in Hughes, H. Stuart, Consciousness and Society. New York, Vintage, 1961.

Alcoholism and the Family

*By R. Margaret Cork**

Most people who have known or attempted to help an alcoholic, have been concerned to some extent with his family. Until recent years, however, few have seen the alcoholic and his family as a unit of interacting individuals, each of whom reacts to, and is affected by, the behavior and the personality of the other. The tendency was to think of the man and the problem in isolation, instead of in relation to significant people in his life. Only as he is seen more fully in this context, and we deepen our understanding

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of him as a member of the family, will we develop more effective treatment skills and possibly begin to move into one aspect of prevention, namely stabilizing the family life for the children of alcoholics.

Early Parental Influence

The alcoholic, like everyone else, began life as a member of the family, and much has been suggested about the role his parents played in his developing alcoholism. While there is a fairly widespread agreement that significant early parental relationships, or lack of them, play a decided role in the development of the personality, there is very little to show why some of those who have suffered certain childhood deprivations become alcoholics.

My concern, however, is with the fact that countless clinicians present, namely, that the personality of alcoholics is affected by early parental relationships or lack of them. This may or may not be true; but it is the presence of certain characteristics, plus the excessive use of alcohol, which would seem to play a significant part in the disruption or destruction of family life. These characteristics would also seem to take on significance in the rehabilitation of the family after the drinking is controlled.

We know from various studies so far that there is no one personality type amongst those who become alcoholics; it has been generally accepted, however, that many alcoholics do tend to have certain characteristics in common. Some of the most frequently observed characteristics which would seem to have particular significance for our consideration of the alcoholic as a family member would seem to be:

— a difficulty in accepting appropriate responsibility
— excessive dependency needs, which often show up as a strong assertion of independency
— a lack of self-discipline often seen in the impulsivity and indulgence of self or others
— a preoccupation with self
— a negative attitude towards authority with consequent repressed or acted out hostility

— a sense of inadequacy in certain vital areas of life
— an unrealistic approach to problems
— limited interests
— shallow or superficial interpersonal relationships which make it difficult to communicate or share with another individual at a mature level.

As we see the alcoholic after the alcoholism has become more severe, these characteristics are often accentuated and may be a source of considerable resentment to the spouse, often greater than the resentment towards the drinking, except possibly in its worst moments. They are frequently the source of considerable or constant marital disharmony before or after the alcoholism develops, depending on such basic factors as the original stability in the marriage, the disturbance in the marital partner, the reaction of the wife to the excessive drinking and consequent social and emotional problems.

The Non-Alcoholic Spouse

As has already been mentioned, the alcoholic does not exist in a vacuum. His personality and his behaviour affects those closest to him, particularly his wife. Because of the inter-action between them, each one helps to keep alive or to accentuate the other's problem. What does the wife contribute to the family problems and/or the on-going excessive drinking? She is often seen as tragic, brave, and patient, a helpless victim of circumstances. The clergyman, physician and friends of the family, counsel the wife of an alcoholic as if she is a stable, capable and non-involved person. This is not true, according to studies made to date. She is not the innocent bystander in a drama of mistreatment and misery. Segall says that she is "equally responsible for the making of the marriage and the participant in the creation of all the pain and unhappiness that follows."

The husband of an alcoholic woman has not been studied to any great extent. However, he has been found by clinicians to be generally less patient and less accepting than the wife, less able to use help, and more likely to terminate the marriage. Fox believes this is due in great part to the wife's capacity to mother, once she

senses her husband's illness, to the greater permissiveness in our culture to drinking amongst males, and to the wife's financial dependence or difficulties inherent in raising children alone.

Alcoholism in the "Normal" Family

I would now like to take a closer look at the families from which the largest group of alcoholics come. This is the family which has had some years of relative stability and meaningful interpersonal relationships, the family in which the father, over a number of years, has been a contributing member, at least financially, and/or socially and emotionally. Whatever personality difficulties and conflicts there may have been in either partner have been accepted or tolerated, or the resentment around such has been held at bay, or sublimated in various ways.

In the eyes of the community, or to those of us fairly close to an alcoholic and his family, it often looks as though the upset to family life occurs just around the recurrent drinking bouts. In some few cases where family stability has been great, it may be so, and with the control of the drinking, family life assumes its former adequacy. But I believe that a very large number of families that are faced with alcoholism already have certain underlying stresses and tensions, certain personality differences and strained patterns of interacting which they are able to handle, but which, with the continued drinking, play their own interacting part in the disruption or disorganization of family life.

Many Fears in Family

What are the feelings, attitudes and ways of reacting which would seem to be common to most or many families as they live through the experience of having an alcoholic member? I list these not in any order of occurrence or of importance. There is in most families at some time the need to hide or deny the problem, a tendency to blame the problem on certain external factors and an attempt to resolve the problems by eliminating or avoiding these; an extension of this is to blame the problem (or accept blame for it) on certain family members.

Fears of all kinds may show themselves, ranging through fear

of what neighbours will say or think, fear of financial deprivation to the fear of whether one is really losing one's mind. Many families go through the experience of protecting the sick member, not so much in a need to deny the problem or to help him, and both can happen, but rather to save themselves from the consequences of loss of job and/or jail sentence. Most wives go through a varying series of attempts to cure him by the oft-mentioned methods of nagging, babying, belittling, isolation, taking over, and submitting to his every demand, including abuse.

In most families there are frequent and constant quarrels and differences that may never be resolved and hurts that never heal. The non-alcoholic partner often lines up the children against the sick parent, or so identifies with his illness that the whole family life and the individual behaviour of its members is geared to keeping the father sober, or coping with the consequences of his last bout. Some wives leave home time and again, usually not because they want to, but to punish or show their independence. Some find a way of going on without the alcoholic partner, almost as if he weren't there, even though they are still under the same roof. Many mothers take on a kind of separation by over-identifying with the children and their interests and needs, to the exclusion of the alcoholic.

Implications for Family Life

There are several general implications of all this on family life if continued over a period of years:

— in relative degree the roles of all family members may become distorted or lost sight of.
— individual members may react and interreact not only to the hurt engendered by the alcoholism, but the normal pains and frustrations of life are never understood and the normal reactions of family members to one another are not given consideration.
— every family member may feel relatively misunderstood without opportunity or psychic energy to work this through.
— the family as a unit, and individually, may become isolated from

normal social contacts and experiences. Individual members are thrown back more and more on one another, with less and less chance of these relationships being satisfying.

— meaningful family goals may be lost sight of, and standards and values that were there before no longer prevail.

— the wife and mother may be so absorbed in controlling the drinking or curing the alcoholism that she has little energy or thought to give to the children's emotional development and problems beyond that of day-to-day care.

— personality differences and inadequacies in both marital partners may become accentuated, which in turn interact on the need to increase the consumption of alcohol. This sets in motion new or increased reaction or interaction between family members and the oft-quoted vicious circle is observed.

The Children — Conflicted and Confused

The children in the family of the alcoholic are of such primary concern to most of us and have all too long been left unstudied, that I would like to comment briefly on some of the particular implications for them of the kind of family living just described. An article on some observations of the normal child states that the normal pre-adolescent gains within the family such things as a well developed time perspective; a sense of trust in the future; a sense of objectivity; ability to delay; tolerance for frustration; realistic non-magical perception of cause and effect; initiative and capacity for taking responsibility; an ability to find answers to problems and confidence in one's ability to meet environmental challenges; and a sense of self-esteem.

Turn, then, to the child who has lived some or a good portion of his life within a family experiencing alcoholism in one of its members, and consider the chances he may have to attain or sustain such normal development. In the alcoholic's family, we see the child pulled many different ways by the parents' inconsistent attitudes toward one another and to other family members, by the amount of hate the parents express and demonstrate and the amount of hurt each has received. The child is conflicted by the mother's taking over the father's role, as well as her own (or to the

detriment of her own). He cannot help but be torn and confused by the different feelings the alcoholic has for him when drunk or when sober, or influenced by the particular hostility directed towards him by one parent, if he resembles the other parent. This child frequently has too much responsibility without understanding, or is indulged by one or both parents in different ways. He is torn by his loyalty to family and what the community feels about his father.

Limited Opportunity for Normal Development

The child experiencing some of these conflicts in feelings cannot help but react and interact with his parents and siblings in a far from growth-producing way. He obviously suffers in a relative degree from lack of strong parental figures on which to pattern himself, from conflict around these figures or from over-identification with one or the other parent. As already mentioned, he may have difficulty in finding his own identity, depending on what age he is when the alcoholism occurs, and certainly he may have a more than usual problem in attaining and/or sustaining his own appropriate role in the family. More specifically, he may be unsure of what is expected of him and what he can expect of others. We find that his needs are often met on the basis of what is happening at the moment, rather than on the basis of his own personality make-up. Many such children have difficulty accepting appropriate responsibilities or in disciplining themselves. Some become fearful of expressing themselves or their feelings, or in their anxiety act these out with considerable aggressiveness.

The general implication in all this is that the child has limited opportunity to grow and develop normally and/or may be severely damaged by such an experience. The miracle is that he survives at all and one questions why so many survive as well as they do. To what degree there is hidden damage which will not come to light until later is an urgent matter for further research.

Family-Centered Therapy Needed

This then, brings us to the matter of treatment. Treatment must be geared not only to the alcoholic, but to the wife, and directly or

indirectly to the children. Such treatment is directed toward getting a better understanding of the emotional factors underlying the alcoholism and the family disorganization, of the interpersonal relationships and interaction of family members. Such therapy for the family is indicated not only because of the interaction and interrelatedness of all who are close to the alcoholic, but because it emphasizes the marriage, because there is more chance for both parents to feel less guilty and more responsible for what happened and for what has to happen to rectify the situation. Such treatment brings a strong element of hope to those who want to find family stability for the first time, or find again or even improve on the family unity they once had.

Whether a wife and husband seek help together of their own accord or individually are sent by some interested party, they both come with many fears, *fears* of the interview experience itself (for this means facing another person who represents authority and there has often been life-long difficulty with such figures), *fears* of what they may be involved in, *fears* of what may be expected of them and of how much it is safe to tell.

Both partners have many mixed feelings about admitting the fact of alcoholism, the marital troubles, and their inability to work things out for themselves. Sometimes both seek tangible answers to the problem, but the wife often has greater difficulty than the alcoholic partner in accepting that cessation of the drinking will not solve all the problems. Often her request for help is in terms of "How can I cure him?" If we fall into the trap of assisting her in this, rather than helping her as an individual to face and work on her own neurotic problems, we do little of lasting value, and she breaks contact as readily as does the alcoholic who is not ready to stop drinking.

The Community Teamwork Approach

Obviously, successful treatment of the alcoholic and his family is a large order. The undertaking of it, if it is to mean more than just control of the drinking problem may seem overwhelming to most individual therapists or counsellors. Experience with the

clinical multi-discipline approach leads me to suggest the development of community teams made up of representatives from the different helping professions working together.

Such a team calls for greater understanding of past failures to rehabilitate the alcoholic. It means a conscious effort on the part of all therapists to stop feeling threatened by one another; to gain a real appreciation of the particular contribution of others; to accept a degree of overlapping; to lose some of the possessiveness and competition to cure the alcoholic. Above all, it means that the alcoholic must be freed to relate to many people without being allowed to play one therapist against the other.

While many professional groups and individuals who are in touch with the alcoholic and his family can play a vital part, four of the professional groups whom I feel have a significant role to play in treatment and prevention in this field of alcoholism are doctors, the clergy, nurses and social workers. A community team made up of individual therapists from these disciplines should not only be able to share appropriately and realistically in rehabilitating the alcoholic and his family but, each member must assume a responsibility for interpreting the illness or the ill person to others in the community.

Need Public Acceptance of Alcoholism

I do not say that community teams are *the* solution to the problems presented by this illness. I do believe, however, that through such an approach, larger segments of our communities might more readily change their attitudes and more quickly lose their fears; that within an atmosphere of community acceptance, thousands of alcoholics and their families not yet getting help, might find the courage to acknowledge their illness; that above all, the helping professions might begin to lose some of their individual sense of apathy, discouragement and isolation, and might individually revitalize and/or revamp their time-tried treatment skills and together, as we haven't been able to do too successfully alone, to find the way to combat an illness which I believe is seriously affecting countless families and the individuals who comprise them. ■

REFERENCES

1. Bailey, Margaret, "Alcoholism and Marriage," Quarterly Journal of Studies on Alcohol, Vol. 22, No. 1.
2. Burton, Genevieve, "The Alcoholic and His Community Search for Help," "Family Crisis and Group Therapy," "Group Counselling with Alcoholics and Non-Alcoholic Wives," reprints.
3. Futterman, S., "Personality Trends in Wives of Alcoholics," Journal of Psychiatric Social Work, 23:37-41, 1953.
4. Igersheimer, Walter, "Group Psychotherapy for Non-Alcoholic Wives," Quarterlv Journal of Studies on Alcohol, Vol. 20, No. 1.
5. Jackson, Joan K., "Alcoholism and the Family," The Annals of the American Academy of Social and Political Science, January, 1958.
6. Lemert, Edwin M., "The Occurrence and Sequence of Events in the Adjustment of Families to Alcoholism," Quarterly Journal of Studies on Alcohol, Vol. 21, No. 1.
7. Mitchell, Howard E., "Interrelatedness of Alcoholism and Marital Conflict," reprint.
8. Raush, H. L., Sweet, Blanche, "The Pre-Adolescent Ego," Psychiatry, Vol. 24, No. 2.
9. Segall, Ruth M. J., "Social Work Approach to Problems of the Alcoholic and His Family," N.A.A.A.P., Detroit, 1958, selected papers.

Second Residential Summer Course

• **Dr. E. H. Botterell,** Dean of the Faculty of Medicine, Queen's University, has announced that the Faculty of Medicine and the Addiction Research Foundation of Ontario will co-sponsor the 1963 Summer Course on Alcohol and Problems of Addiction.

The course, which will be held on the campus of Queen's University from June 9th to 21st, will again be directed towards those persons, who in their professional capacity, are concerned with problems associated with the use of beverage alcohol.

Dr. S. G. Laverty will represent the Queen's Faculty Board on the Course Planning Committee. Inquiries about the course should be addressed to Gordon M. Patrick, Assistant Director of Education, Addiction Research Foundation, 24 Harbord Street, Toronto 5, Ontario.

Addictions

Volume 9, No. 4, Spring, 1963

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ALCOHOLISM & DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO

This periodical is published four times a year in the interests of a deeper understanding of the widespread disorder alcoholism and other forms of addiction.

Each issue contains pertinent, factual information selected primarily because of its interest to those who are called upon to deal professionally with alcoholics and other addicts. Articles published do not necessarily represent the views of the Foundation.

If you would like to receive this publication regularly, or if you wish additional information about some aspects of our work, you are invited to write to the Alcoholism and Drug Addiction Research Foundation, Education Department, 24 Harbord St., Toronto 5, Ontario (365-4521).

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It is becoming more generally recognized that advertising illustrations presenting photographs of "life-like" scenes and the "realistic" sets designed for television and motion picture plays are providing mass North American audiences with distorted images of what their way of life should be like. The disparity between the living room shown on the screen or on the magazine page and the size, quality, and condition of the furnishings surrounding the over-mortgaged, bill-swamped viewer is often painfully marked.

This painful awareness of the degree to which most people fall short of such fictional "norms" undoubtedly makes for a great deal of dissatisfaction, and prods many people into a hurtful and unsettling state of chronic over-striving. It does them and their children no good.

In the same vein, what of the effects of the fictionalized norms of alcoholic beverage consumption dreamed up by advertising agencies and the playwrights and their directors? Do these, too, encourage the middle class strivers of North America to buy and serve and drink a greater quantity of more expensive beverages than they can reasonably afford? And if more or less responsible parents are so influenced, what of their emulating offspring?

One last question: To what extent might it be said that the social and economic over-striving of many North American parents in itself creates or greatly enhances the need for over-drinking?

— R.R.R.

A Clergyman's Viewpoint on Alcoholics Anonymous

*by Frederick G. Lawrence, M.S.SS.T.**

The title of this paper is very important. I have been asked to give *one* clergyman's viewpoint on Alcoholics Anonymous. I shall endeavour to do just that. Not any other clergyman's viewpoint. Just mine. It shall differ, I am sorry to say, from what you may have heard or read expressed as the viewpoint of other clergymen on this subject. But I can speak for no one save myself. My opinion, my viewpoint is the result of many years of close association with Alcoholics Anonymous, a little formal education in regard to the problem of alcoholism, but mostly, it has been formed by the edification and inspiration, the veritable miracles I have seen wrought, in the Alcoholics Anonymous fellowship. At the end of the paper, I have listed some of the chief references to the work of Alcoholics Anonymous.

Alcoholics Anonymous Best Therapy

First of all, therefore, let me express my viewpoint on Alcoholics Anonymous. Then will follow the "why" of this opinion. *To me, Alcoholics Anonymous is the best therapy existing today for assisting most active alcoholics to a maintained and a happy sobriety.*

I say it is the "best" therapy, because there are others that have achieved, if even in a lesser degree, some success in the treatment of sick alcoholics. And the adjective "most" precedes the words "active alcoholics" because some, due to a neurotic condition, a deep-seated psychosis, or definite brain damage, need professional

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* Father Frederick G. Lawrence, M.S.SS.T. is the Custodian of St. Joseph's Villa in Stirling, N.J., which is "an in-patient long-term clinic" devoted to work with clergymen who have become victims of alcoholism. This article is reprinted from "Problems in Addiction: Alcoholism and Narcotics", edited by W. C. Bier, S.J., Fordham University Press, New York, 1962, with permission of the author and the publisher.

medical care, which A.A. as such, cannot offer. Finally, the words "maintained" and "happy" condition the noun "sobriety," for I see little value in sobriety that is not lasting, and even less value in sobriety that is not enjoyed or happy.

A Viewpoint Born of Gratitude

Now— an explanation on why I entertain such a viewpoint. May I beg your indulgences as I tell you how my interest in A.A. first came to be? It was born of gratitude; gratitude to God for an answer to a seemingly insoluble problem. One year after ordination, filled with the zeal of St. Paul, I was placed in charge of a geographically large, numerically small parish in southeastern Alabama. Of the 65,000 souls who lived in the 3,500 square miles serviced by our parish, only some 35 to 40 were Catholics. Yet, into this small number God tucked one very, very sick alcoholic. I tried to help her to correct her problem. Every spiritual aid I could think of was suggested and tried — the pledge, novenas, the rosary, aspirations, spiritual communions, frequent visits to the Blessed Sacrament, even daily Mass and Communion. Nothing seemed to effect the desired results. As a matter of fact, the problem grew worse instead of better. Six months after I had been introduced to this poor woman, she, on her own, joined A.A. When, after a period of a month's sobriety, she invited me to attend an open meeting, I was so grateful to God for the success she was having, and so curious to see what caused it, that I went. It was definitely a case of "I went; I saw; I was conquered," for I have been going to A.A. meetings ever since, and that first one was in January of 1946. And — lest you wonder — my parishioner who joined at that time is still sober and active in A.A.

Some Questions and Answers

Generally, in speaking with clergymen about my interest in Alcoholics Anonymous, I am asked a series of questions. I feel the answers to these questions will very well cover my viewpoint on

Alcoholics Anonymous, and therefore I would like to present them to you today.

First of all — *Did I find anything new in A.A.?* Not exactly. What I heard, read, and saw had a very familiar note in the beginning. Later I realized that the A.A. philosophy was basically nothing more than a Christian way of life, presented in a little different fashion, perhaps, and disguised in a new vocabulary, but fundamentally the teachings of Jesus Christ. Undoubtedly, this is what made it, from the very outset, so attractive to me.

A.A. — Perplexing or un-Christian?

Did I find in A.A. some overpowering, perplexing philosophy? Again the answer is "no". It is a simple program, with twelve simple suggested steps, and simple mottoes, such as "Think" — "Easy Does It" — "A Day at a Time" — "Live and Let Live" — "But for the grace of God". I found the members to be as simple as children, as sincere as saints, and I remembered that a requisite for sanctity is that we become as little children.

Did I find anything un-Christian, or un-Catholic about A.A.? Most decidedly not! Rather did I find in A.A. a wonderful specific alignment of Christ's teachings as applying to *this problem.* This program not only does not contradict any Faith of any adherent, it actually complements their faith. I found that Catholics who lived the A.A. program were better Catholics because of A.A. As a matter of record, I might say I have never seen the virtue of charity, the great commandment of love of neighbor, more universally practiced than I have seen it lived by the members of A.A.

Why has A.A. been successful when so many other programs have failed? I believe that the first among these reasons is the recognition on the part of A.A. that alcoholism is a threefold sickness. For centuries the human race has considered, accepted, and discussed alcoholism as being basically, essentially, if not exclusively, a moral problem; an evidence of lack of will power on the

part of those afflicted. It is my considered opinion that most people *still* view it in this light.

Alcoholics Anonymous, on the other hand, maintains that alcoholism is a sickness of the body and mind, as well as of the soul. Thus the A.A. therapy suggests a correcting and eliminating of the spiritual problem that afflicts all alcoholics to a greater or lesser degree. A.A. members further maintain that neither the physiologist, nor the psychiatrist, nor the clergyman *alone* has the answer, but all three must work together. A threefold correcting must be affected or *no* lasting results can be produced.

To draw an analogy with the famous story of "The Leak in the Dike," had there been three leaks, instead of one, the little lad's finger could not have averted the disaster. Three fingers would have been necessary or destruction would have ensued.

A Simple Program — But Not an Easy One

Why do I think A.A. works? Because it is a positive program of rehabilitation, and every alcoholic needs, in some degree to be rehabititated, not imprisoned or incarcerated, not condemned or ridiculed, not shunned or over-protected. A.A. does not simply ask the alcoholic to stop drinking, as we do when we administer a pledge. A.A. suggests a new way of life to the alcoholic, and then makes suggestions as to how he may follow it. Sobriety is basic, essential, a "sine qua non," if you will, but like Baptism — it is only the beginning. The twelve suggested steps lead to a serenity for which the Alcoholics Anonymous members plead in the very first line of their so-called "A.A. Prayer"; — "God grant me serenity." And the effectiveness of the A.A. program in the life of its members is in direct proportion to the success they have in accepting, understanding, and applying these twelve steps to their lives.

A.A. is a simple program, but it definitely is not an easy program. "Easy does it," but the alcoholic has to *do it!* The twelve steps are but tools to be used by the alcoholic in sculpturing from the clay of a broken life, a new existence. But, *he* must do it! No

one can do it for him. He is simply presented with the tools. He produces their effectiveness. Gathering dust from lack of use, growing dull from lack of understanding, the steps are useless. But taken one by one, and applied to daily living, they can make of the most desperate derelict, an edifying image of the God Who dwells within us all.

What is the nature of the A.A. therapy? A.A. is a program of education, or introspection, if you will. It borrows from the ancient Greek philosophers the admonition, "Know thyself," when it suggests each member take a "searching and fearless moral inventory." Being creatures of habit, it is important that the member of A.A. recognize the habits that rule his life. He must decide which habits are good, and which are evil; how the good can be developed, and the evil eliminated. Thus A.A. members talk of removing "wrongs, shortcomings, defects of character." The desired goal is the *habit of sobriety*. It is acquired only by much practice, much determined action, much accentuation of the positive and eliminating of the negative.

Substituting Virtue for Vice

A study of the twelve suggested steps will reveal that each required the practice of a virtue where once vice or imperfection ruled. Thus the first step suggests humility be substituted for pride; the second, faith in God for self-conceit; the third, trust in God for despair; the fourth, truthfulness for falsehood; the fifth, simplicity for duplicity; the sixth, sincerity for shame; the seventh, meekness for arrogance; the eighth, love of God for love of self; the ninth, honesty for hypocrisy; the tenth, fortitude for insincerity; the eleventh, prayerfulness for godlessness; and the twelfth, love of neighbor for intolerance.

Finally, *what is the secret of continued success in A.A.?* I think it depends upon the member's ability to maintain his "sense of awareness." He cannot afford to forget. For him, it takes a lifetime to be a success, just a second to suffer a relapse. His creed is:

"Once an alcoholic, always an alcoholic." His is a sickness that can be arrested, but never cured. One drink shall always be too many, a thousand never enough. And this "sense of awareness" is best maintained, all A.A. members will tell you, by attendance at meetings; associating with other members; reading the A.A. literature; applying the twelve step program to their lives twenty-four hours of every day, a day at a time.

A.A. Can Assist the Counsellor

This, therefore, is my viewpoint on Alcoholics Anonymous. It is the best therapy existing today for assisting most active alcoholics to a maintained and a happy sobriety. I hope the reasons given have been sufficiently sound to induce you to agree with me. If so, then my admiration and enthusiasm for this Christlike fellowship will have won it new friends among the clergy. If so, then more alcoholics will receive the understanding, sympathy and counsel that they need from those of us who have been ordained to help all men attain their eternal destiny — to be happy with God forever. It is my prayer that all of you will allow the fellowship of Alcoholics Anonymous to assist you in helping all alcoholics achieve this goal. ■

REFERENCES

Alcohol, Science, and Society. New Haven: Quarterly Journal of Studies on Alcohol, 1945.

Alcoholics Anonymous. New York: Alcoholics Anonymous, 1955.

Alcoholics Anonymous Comes of Age. New York: Harper, 1957.

Ford, J. C. (S.J.), Man Takes a Drink. New York: Kennedy, 1955.

Ford, J. C. (S.J.) & Kelly, G. (S.J.), Contemporary Moral Theology. Westminster: Newman, 1958, Chapter 13.

McCarthy, R. G. & Douglass, E. M., Alcohol and Social Responsibility. New York: Crowell, 1949.

Mann, Marty, Primer on Alcoholism. New York: Rinehart, 1950.

Group Marriage Counselling In an Alcoholism Clinic

By Imre Nemeth, B.A., M.S.W.

EDITOR'S NOTE: *When preparing this article for publication, Mr. Nemeth added the following postscript. We feel it is worth reproducing here, at the beginning of the article, because it expresses so well some of the aspects of therapy seldom, if ever, reported in scientific papers.*

"Postscript — Although the previous statements were observations made with the explicit purpose of furthering the accumulation of knowledge in the field of treatment, they do not tell the whole story. The whole story, as every human story, is much wider — it has too many aspects which are only implied.

"It does not tell about the events as they unfolded, the friendship and solidarity which sprang up among us, the heart-breaking suffering which we experienced when one of us was in trouble, the search for truth, and the struggle for understanding, the doubts and the occasional light which goes under the name of therapy, the laughs and the jokes we shared, and the encouragement which we gave and received.

"These aspects usually do not appear in scientific articles. The cold light of reason demands detachment and objectivity. But these meetings became part of my life as I am sure they became part of my patients'. We shared an experience which can be measured and analysed, but which cannot be repeated. It was hard work, learning, therapy, scientific observation, but it was also good companionship and a privilege, and for all this, I am very grateful to all of those who participated in it."

Mr. Nemeth is a psychiatric social worker at the Toronto Clinic of the Alcoholism and Drug Addiction Research Foundation.

Many projects in clinical settings arise under the pressure of necessity. We had a number of patients in the Toronto Clinic who had, besides their alcohol problem, severe marital difficulties. We found, that in many instances, when we interviewed either the non-alcoholic spouse or the patient regarding the marital problem, the interviewee would settle down to listing grievances and would refuse to look at himself or herself. We attempted to cope with this situation in several ways — interviewing husband and wife alternately, or arranging joint interviews. None of these methods worked out too well at the clinic. The projective mechanism of the patient and the spouse frequently turn against the therapist who is seen as an authority figure arbitrating between them, rather than as a professional person who is providing service at the demand of the patient.

These considerations resulted in the idea that bringing together several couples who could identify with each other, provide mutual alliances to protect themselves against anxiety, interpret each other's difficulties, and gain insight from each other's problems, would be a better solution. We also had the impression that it would save time to see several couples together rather than to see them separately.

Anticipated Difficulties

We were rather worried about the possibility that people brought up in the tradition that marriage is an entirely private matter would be quite reluctant to discuss marital problems in the presence of others, or if they were willing to discuss them, the discussion would remain on a rather superficial level. Another worry was that group psychotherapists, especially those psychoanalytically oriented, warned seriously against having husband and wife in the same group because, according to them, the introduction of a reality situation would hinder the development of the transference to the therapist. There were other considerations which created some theoretical or practical difficulties. One article on group marriage counselling described a group consisting of alcoholic husbands and

non-alcoholic wives, who had to struggle for a long time before the women stopped lining up against the men.

The Selection of Couples

After some consideration, five couples were selected and approached. All five accepted group counselling. The occupational characteristics of the group were: a professional person, a civil servant and three businessmen. Two of the women had professional training and the other three were working in secretarial jobs. The educational level of the group was higher than average and so was the intelligence of the participants. All the couples were comfortably off financially and compatible socially.

As to personal and marital difficulties, two of the men were patients of this clinic and two of the women have been treated as inpatients. One couple was seen only for marital counselling and drinking played only a minor part in their lives. However, this couple was actually separated at the time when they came to the clinic. In every instance there was alleged or actual infidelity, a great deal of open or latent hostility and bitterness directed against the partner, differences regarding the upbringing of the children, a sharp focusing on alcoholism, accusations that the other party is at fault, trouble with in-laws, and so on.

Three couples had contact with a psychiatrist or a social worker before they came here. All of them received individual treatment at this clinic, either by a psychiatrist, medical doctor or social worker before they joined in the group.

Theoretical Considerations

Since there was little encouragement for this type of group counselling in psychoanalytic literature and most references were based on practical experience rather than theoretical considerations, it was decided that theory would be used sparingly and we would

just "play it by ear" as we went along. Difficulties were anticipated in getting the discussion under way and it was decided that insofar as the group would require encouragement, we would discuss the theoretical aspects of marriage and rely mainly on role theory.

Subsequently, it was found that we had to rely on any theory that came in handy in the interpretation of a particular situation. Sometimes interpretations were far-fetched due to three factors: because we sensed a great deal of anxiety in the group; secondly, because of the therapist's own anxiety about a particular topic; and, thirdly, because interest in a particular theory ran away with us.

In spite of these faults, no damage was apparent, but probably the progress of the group was slower than it would have been otherwise. The main theoretical concepts used were taken from anthropology, sociology and psychoanalytic theory.

Cultural Values and Moral Indignation

In the first area, discussion of cultural values came up again and again. Needless to say, moral indignation was one of the weapons which the couples used against each other and their fights were always accompanied by hostility and bitterness. For example, in spite of verbal acknowledgments that alcoholism was an illness, the alcoholic partners were often attacked by their non-alcoholic spouses. Accusations of philandering were directed against the husbands, and accusations of nagging and being domineering against the wives. Most of the men insisted that they had the right to their freedom and the women insisted that they had the right to demand conformity to family needs from their husbands. The situation was somewhat different with the couples where the wife was the alcoholic.

It was in the area of values that the greatest difficulties were encountered. In the beginning the therapist could not decide whether he should stay morally neutral, interpret social norms from the sociological or psychiatric point of view, or whether he should

attempt to represent a kind of ideal morality which would transcend local custom and individual conscience.

Actually interpretations were formulated on four theoretical bases. Values were interpreted (a) as social norms necessary for an orderly society; (b) as derivations from emotional needs expressed in complementary and competitive roles; (c) as expressions of the historical tradition of a given culture; and finally (d) as existential values which the individual confronts on the level of being and nothingness.

Use of Existential Concepts

In spite of the fact that the last position was intellectually the most difficult to explain, and for the patients, the most difficult to grasp, it always put the discussion on a very profound basis and produced the most genuine feelings of both anxiety and insight. Social role theory gave some help so far that the therapist was able to interpret to the group difficulties which were inherent in the institution of marriage rather than in their personalities. It helped to present an objective point of view and promoted reasonableness, but it was not felt that it satisfied the emotional needs of the group. It served the purpose of giving prescriptions for behavior and adopting a stoic and accepting attitude, but it did not produce either insight or catharsis.

Interpretations which were based on the psychodynamic point of view were more fruitful. Psychoanalytic terminology was not used of course, but a few times it was quite helpful to interpret phenomena in terms of a conflict between Id and Superego, to trace a particular difficulty back to childhood roots, to emphasize unconscious motivation, and symbolic or somatic expressions of emotion and so on. The limitations of psychodynamic theory were manifest mostly when interaction between a married couple had to be interpreted.

Although existential concepts were not used explicitly, we often differentiated between relationships on the basis of Buber's "I and

Thou" versus "I and It" concept. Without relying on the spirit, if not on the more esoteric ideas of existentialism, work with the group would have been much poorer. Time and again it was felt that the therapist was confronted with one or several patients, or with the whole group, on the level of being or nothingness, discussing the meaning of life and relationship. Certainly none of the psychological or sociological theories would have given much guidance on how to handle such a situation. Implicitly, they refer such problems to the realm of psycho-social maturity, but then acknowledge that this involves a personal philosophy, a system of values and convictions which, according to them, should not enter into therapy. Existentialism gave both the justification and the proper methodological attitude to deal with this problem in such a way that the therapist managed to be authentically involved and at the same time refrain from personal judgment or imposition of his own values.

The Beginning Sessions

The initial intention was rather modest. We assumed that the group would be rather reluctant to move into sensitive areas and that if genuinely disturbing problems would come up, they would try to escape them. In order to avoid embarrassment, it was suggested that we should meet only for ten sessions and then discuss whether we wanted to continue or not. This way we could have terminated the group discussions without a sense of failure.

The first few sessions were rather tense. Some of the group members moved in quite quickly, partly because their own anxiety prompted them to break silence. In spite of this, however, the discussion did not move beyond theoretical discussions of marriage, rather detached remarks about difficulties, and occasional stereotyped accusations against the other partner. As we moved along, however, the discussions started to become more meaningful as, one by one, the group members became willing to commit themselves emotionally to the group.

Two types of group interaction became prevalent. One was the ganging up, for or against, one of the group members. One

example of this occurred at one of the beginning sessions when a husband started to accuse his alcoholic wife with different unacceptable behavior during intoxication. Two alcoholic men adopted an almost physically protective posture, and the whole group attacked the husband for his lack of understanding. The other slightly modified form of this group interaction occurred when one member started to confess some recent or past misdemeanor, and the group and the therapist tried to provide interpretations of this behavior. This group formation became so typical and well recognized that the group members assigned, jokingly, a particular chair where the accused would sit, and referred consistently to this phenomenon as being "in the hot seat". This way of dealing with an individual problem was a later development as, in the beginning, the group was quite unable to handle confessions and individual members were quite reluctant to "stick their neck out".

Outbursts — Meaningful and Helpful

The second way of interaction which developed was that a married couple would start to discuss a particular issue which was painful, or was not discussed privately, or which had previously led to a sharp conflict. Sometimes this interchange was quite violent, with mutual insults, recriminations, attacks and a great deal of feeling. A few times the argument went on outside the group and at the next session it was picked up again. This was the most useful kind of interchange because it was always possible to provide some meaningful interpretation of what went on and invariably the marital situation improved after such explosions.

The group was asked just before the ten sessions were up, whether they wanted to continue, and then again, before the twentieth session. Since then, the question has not come up. Most members regard Thursday night as a part of their life. This is somewhat surprising because in the very beginning, when the length of the group participation was discussed and it was suggested that a group may go on for a year or even two, most group members saw

this as an exaggerated length of time. At present, we have been meeting for over 10 months.

There were some fluctuations in participation and the meaningfulness of discussions as well as crises. In the beginning, most group members turned up quite regularly. During June to September there was frequent absenteeism and at the end of the summer, especially in August and September, there were some sessions when only five or six members participated. This was also a time of relative calm and the group meetings weren't particularly meaningful.

It was only after about 15 meetings that the group started to acquire a feeling of solidarity and security with each other. Since then, it hasn't been a problem for the group to "let their hair down". At this stage we worked through some fundamental problems with each couple, and there is now a keen awareness of the sources and forms of problems. The future course of the group is likely to be a gradual building up of more and more positive attitudes toward the problems which, at this point, are fairly well recognized. There is only one couple who has not had too much benefit from the group as yet.

Structure of the Sessions

Apart from the five couples and the therapist, there has been from the very beginning, a nurse present who took notes about the group sessions. Half-way through the group session there was a coffee break, the nurse playing the role of hostess. This arrangement was extremely important for two reasons. One was that apart from having some record about the sessions, the nurses who participated in the observation often were able to observe points missed by the therapist and provide a different interpretation of occurrences in the group. The other point was that the presence of a man and a woman therapist, one active and one passive, brought an element of balance into the group structure. This structural arrangement brought us closer to the group, made the group members less defensive, both regarding the social distance between patient and therapist and the

negative status evaluation which the patient could have versus the therapist.

The structure of the discussions was rather varied. In general, one of the group members started by asking other group members what had happened since the last meeting. Sometimes the therapist started out the discussion, especially in the beginning, by recapitulating the last discussion. On a few occasions some group member voluntarily presented a problem. The discussion then usually developed around a dialogue either by a married couple or by two group members, the rest of the group making comments, agreeing or disagreeing. The group generally looked to the therapist to make interpretations but during the last few months, more and more interpretation came from group members themselves. An attempt to foster this trend was made by including in the interpretations all the remarks which were made by group members either in that session or earlier. On a few occasions, group members challenged the therapist. More often, of course, he challenged them. This always had a stimulating effect on the discussion. On the other hand, a too neat or theoretical interpretation usually stifled the discussion.

Discussions — Purely Partisan to Reasonable

The content of the discussions varied also. For example, one topic was how the husband should spend his leisure time, when he should come home and what kind of pastimes he should be entitled to. Another topic was the domineering and nagging of the wives. The management of the home and the differences between the orderliness or the carelessness of the marital partners was often discussed. Unrecognized temperamental differences were another area of discussion and we spent considerable time exploring the differences between two types within the group: one characterized by searching and following rules, the other searching for excitement and acting impulsively. Self-centred attitudes and different manoeuvers to protect themselves from

the other were frequently our concern and so were the persistent misunderstandings due to projections determined by anxiety. Financial problems and problems with children came up less frequently. On the other hand, discussions about in-laws featured quite prominently. The men as well as the women discussed their work relatively frequently but this was not a major conflict area.

The method of discussion in the beginning was purely partisan. Couples or group members engaged in increasingly sharp verbal encounters and the rest of the group either sided with one or the other or lapsed into anxious silence. As we progressed, the discussions became more and more reasonable, even though more and more genuine emotion came to the surface. The group members were very sympathetic and very helpful when they saw a couple struggling through a particular problem. Sometimes the interpretations of the group members were extremely shrewd and very much to the point. On the other hand, there was some pseudo-learning about therapeutic interpretations and occasionally it happened that one group member would use therapeutic language or concepts as a weapon against another.

Interpreting Crises

There were a number of crises which the group members lived through and discussed in group sessions. They were related to drinking episodes, or anxiety in anticipation of one, physical illness, hospitalization in this clinic, violent arguments about sex or nagging, in-laws interfering with home life and redecoration of the home.

We seldom attempted to trace these crises back to psychodynamic factors, but interpreted the interpersonal and social significance of the event. Thus, to some extent the focus of group treatment was outside of the group inasmuch as the events outside were brought into discussion. It was our goal to bring about change in attitudes by eliminating distortions in the perception of these events. It occurred again and again that a couple would describe a situation

and express surprise, anger, anxieties, indignations at the different interpretation which the other spouse gave to the event. More than once it was possible to point out the defensive or aggressive nature of these distortions and then develop insight.

Some Results

The results of the group up-to-date are quite satisfactory, both objectively and subjectively. Of the four group members who had a drinking problem, one achieved sobriety while the group was going on. Two others maintained sobriety which they had achieved before they joined the group. The one remaining group member who is still struggling with a drinking problem also shows improvement. The couple who separated, reunited again. Three group members achieved extremely good insight into their personality dynamics and the difficulties which they experience in their marriage. There was a definite positive change in their personality makeup. Four other members made positive steps but their self-understanding and mastery of their personality difficulties is not consolidated. The remaining members also benefited but they show this only implicitly, mainly because their verbal participation is minimal.

Subjectively, all group members stated this was a very satisfying learning experience. As for the therapist, it was probably one of the most meaningful therapeutic projects ever engaged in. This experience offered another demonstration of the feasibility of handling marital problems in a group. However, it did not yield a particular technique that would be generally applicable to any group. ■

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Our rate of progress is such that an individual human being, of ordinary length of life, will be called upon to face novel situations which find no parallel in his past. The fixed person, for the fixed duties, who, in older societies was such a godsend, in the future will be a public danger.

— Alfred North Whitehead

A G.P. Looks at the Alcoholic

by R. A. Whitman, M.D.

EDITOR'S NOTE: *There is no such single entity as "the alcoholic": there are many kinds. It follows, then, that there should be many different approaches to the treatment of alcoholic individuals. What follows here is an approach to the kind of alcoholics with which one general practitioner has achieved a successful experience over a period of 14 years.*

Dr. Whitman is a Hamilton, Ontario, physician who is currently president of the Ontario Chapter, College of General Practice of Canada.

Every problem is a challenge and every challenge has certain odds — if the chances of success are good, we welcome the challenge; but if our past experiences have been marked by failures, we dread facing yet another.

From my limited experience in treating alcoholics over the past 14 years, it seems that one of the most important factors bearing on the eventual outcome of any treatment program is the motivation of the patient. If he wants sobriety, he will cooperate with any physician who will show him understanding, compassion, a modicum of confidence, faith in his sincerity, and an honest desire to help him understand his problem and make tolerable his recovery to sobriety. This recovery doesn't have to be entirely painless; but the worst distress should be relieved as in any other illness.

Most alcoholics, once they are off the drug, have a terrific amount of drive and aggression. They will work like Trojans for a goal; but they have only a very limited tolerance of the limited drive and fatigability of most other people. They are easily frustrated, and

very sensitive to disappointment and to the loss of confidence and faith in them by anyone. An alcoholic loses faith in himself just as quickly. But he is equally sensitive to encouragement, displays of trust, dependence on his reliability, and genuine acceptance of himself at face value. Accentuate his positive assets; praise him when he deserves it — he is not allergic to soft soap.

Treat with Honesty, Candor

Psychologists emphasize the immature personality of alcoholics. We are called upon to treat them, often as the head of a family which may be a shakey, if not already shattered, social unit. We must bear in mind that although alcoholics have usually reached a maturity in years, we must still regard them as somewhat adolescent, particularly from the point of view of responsibility which they have generally shunned and evaded — although they expect more than average privileges. They have been accustomed to getting away with it; they have also been in the habit of deceiving and being deceived. Being treated to absolute honesty, candor and frankness is often a rude jolt, but it is usually accepted maturely and can win respect.

Speaking the man's own lingo — the dialect of the lush — but without disparagement, and being totally free of any "holier than thou" attitude, are necessary in establishing the rapport which is vital. This rapport is probably the second most important factor in the successful treatment of an alcoholic, since you must convince him of three things before he will accept your advice: first, that you know what you are talking about; second, that you know exactly what is wrong with him; and third, that you know what you and he must do about it. Then you must give him a logical plan of action, explaining at least a little about it. This plan will depend on the stage of his alcoholism when you see him.

I insist that an alcoholic patient have at least 24 hours' abstinence before I will treat him. Alcoholics Anonymous members, and others, know this and seldom press for an appointment in much less

than that time. This tends to screen out many alcoholics who are guaranteed failures — those who don't really want sobriety — just help to continue drinking and social support for it. If you get a reputation for firmness, maintain it. It adds to your prestige and effectiveness.

Examine His Drinking History

When a man or woman has endured the first 24 hours of acute withdrawal, he or she is usually not only willing, but anxious, to cooperate in getting help. Be prepared to give at least one half-hour for the first interview. Get as good a history as possible of how alcohol has afflicted his career, and confirm the facts you get with his companions, escorts, family, and so on.

When you have done a fairly complete physical examination, you have a good mental image of what he has been and is now. Take a few minutes to explain to him how it has all come about. You can usually generalize, and the hat will appear to fit:

> "You began to drink, socially, to keep up with the gang, to be one of the boys. Then you discovered that you could drink them all under the table and have no hangover the next morning. That was a source of as much personal satisfaction to you as your cousin or your brother got out of their baseball, skiing, or football skills and achievements — and with much less work. But very soon you found that your 'rosy glow' had its penalties. You got into social problems, had to stretch the truth a bit, invent alibis and so on, but soon you could face these penalty situations bravely, almost comfortably, with a little drink to bolster or fortify you. You were hardly aware that your daily requirement was increasing, and that the same 'trusty friend' would 'cure' any kind of ill, physical or emotional, and that you didn't have to endure the slings and arrows of an unkind fate. You were not quite aware that you were 'hooked', that you had no time for family, hobbies, church, hardly even for work.

"Then, suddenly, someone lowered the boom. You had no family, no job, and no security, no independence and few friends, no place to hang your hat. 'Maybe I'd better start tapering off' — (No, George tried that and it didn't work). I'll take a trip and get away from all my bad habits and old friends' — (geographical 'cures' are less reliable than the perfect climate; your habits shadow you). 'No, I'll get some happy pills at the drug store to settle my nerves so I won't be so grumpy'. That's how you kick it. Get on the happy pills."

Chances are, he already is on the happy pills — particularly so if he has seen two other doctors recently. If he is using the pills, he will want to know how you knew this. Assure him that you do not want to see him doubly addicted, and that if he already is on the pills, to be honest and own up.

Treat His Bodily Ills Too

Explain why he needs to take a multiple vitamin or preparation high in the B complex, especially in Thiamine. If he is not taking such a preparation, start him on one — only never prescribe one in a liquid form because it may have an alcohol base!

If he has gastritis and/or hepatitis, treat these diseases. He probably has had a deficient protein intake, so emphasize protein in his diet. Force him to drink fluids, especially milk, until his gut can tolerate solids. If you have to sober him up, do it at home if at all possible — the price he pays is higher, and his sobriety is that much more valuable. If necessary, a few days in hospital will permit packing more glucose, intravenously, into the liver until the vomiting is controlled and the body re-hydrated. This offers the opportunity to: (a) help restore cerebral cortical functions and cerebellar control; (b) prevent D.T.'s; (c) restore appetite; and (d) head off the sequelae of peripheral neuropathy.

Use this receptive phase of recovery to indoctrinate him (brainwash, if you will), to impress him of the necessity of sobriety, of all

the help available to him from any or all of the community agencies, and of the services that can be used for rehabilitation. Inform him of the help available from special treatment counselling organizations such as the Addiction Research Foundation, the church of his faith, and Alcoholics Anonymous. I insist that all my new alcoholic patients go, sober, to at least one A.A. meeting. Some will get additional help, understanding and encouragement from Recovery Incorporated.† A constructive hobby should be started or revived as a source of personal satisfaction — something from which he will derive pride, enjoy learning all about, and in which he can become expert.

Handling a "Dry Drunk"

Now, if you meet your alcoholic patient when he is in the late withdrawal phase — a "dry drunk" — he may tell you that he has been sober anywhere from four to six months up to three or even five years. He has now reached the verge of his first slip. While he is fidgeting, squirming, sweating, nervously puffing cigarettes and changing postures, and pulling a very long face, tell him that you can see that he is irritable, restless, can't let his feelings go, can't eat or sleep properly; that he is full of fears, especially regarding his sanity; and that he is suffering a painful degree of loneliness worse than anyone else has ever suffered. He is so confused that he can't seem to concentrate on anything for more than a second before other ideas crowd in and become all mixed up. He faces three choices:

(a) to go out and get drunk, an idea which he has at least partly rejected or he wouldn't be here;

(b) to go to a mental hospital to regain his sanity, an idea which he secretly feared would be the advice given to him when he decided to come and face his problem;

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† Recovery Incorporated is a self-help program, with no professional supervision, for people with emotional problems. The group, which originated in the United States, is small in Canada.

(c) to continue to face and endure these intolerable "nerves" a little longer, and to win because he is only going through a normal part of his adjustment, however delayed, to sobriety.

Be a Straight Shooter

This phase is to be expected, and could have been predicted had you seen him early in his sobriety. Tell him that he is suffering a dry drunk, that it won't last forever, and that he will survive it. When he finishes, heaves a great sigh of relief and begins to relax, ask him if he didn't have blackouts and an abnormal capacity for drinking with minimal or no hangovers. He will then believe your advice, take your Thiamine, busy himself with a hobby, and get back into his A.A. activity from which he withdrew because of all his old aggression. In a week, he will have forgotten how sorry he felt for "poor me".

These people are so grateful for a patient listener — a counsellor who is a straight shooter, who will avoid all possible technical terms, who will talk their language and, at times, just listen. They treasure honesty and frankness. Call a spade a spade, and forewarn them of the rough road ahead. But invite them to come in and see you before ever going back to the bootlegger or to the pub for help. ■

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Reverence for life . . . does not allow the scholar to live for his science alone, even if he is very useful . . . the artist to exist only for his art, even if he gives inspiration to many . . . It refuses to let the business man imagine that he fulfills all legitimate demands in the course of his business activities. It demands from all that they should sacrifice a portion of their lives for others.

— ALBERT SCHWEITZER

Barbiturates — Friend or Foe?

*by S. J. Holmes, M.D., D.Psych.**

The barbiturate problem has been described by Isbell and his group from Lexington, Kentucky, as more devastating than opiate addiction. Opiates cause much less impairment of mental ability and emotional control and produce no motor incoordination. Furthermore, such impairment as does occur becomes less as tolerance to morphine develops, and there is not the wide variation in response to the daily dose. In addition, the withdrawal from morphine is not as dangerous as the withdrawal from barbiturates.

The production for consumption of barbiturates since the introduction of the drug in 1903 in its various forms and under its various trade names, has shown a progressive increase. In Canada, all barbiturates are imported, and imports have been increasing by approximately one ton a year since 1952. In 1951, approximately 24,855 pounds of barbiturates were imported into Canada; this figure increased to 36,175 pounds in 1952. In 1962, imports of barbiturates totalled 57,450 pounds. In comparison, there was an increase of prescribed barbiturates in Great Britain from 90,000 pounds in 1951 to 162,000 pounds in 1959. About seven per cent of all prescriptions issued in Great Britain were for barbiturates and about two and a half per cent were for stimulants.

Three Groups of Barbiturates

The Division of Narcotic Control, Department of National Health and Welfare of Canada, divides barbiturates into three groups: short-, medium-, and long-acting in their effects. In the short-acting group are hexobarbital (Evipal), pentobarbital (Nembutal), and secobarbital (Seconal). In 1962, imports of these short-acting drugs totalled approximately 15,114 pounds in straight form,

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and 70 pounds in the form of preparations. In the intermediate-acting group are amobarbital (Amytal) and butabarbital (Butisol); imports of these drugs in 1962 totalled 18,854 pounds in straight form, and 473 pounds in the form of preparations. Barbital and phenobarbital fall within the long-acting group; imports of these drugs in 1962 totalled 22,105 pounds in straight form, and 833 pounds in the form of preparations.

Difficult to Estimate Addiction Rate

This increase in barbiturate production has come during a period when there has been an almost astronomical increase in the production and consumption of tranquilizers. The significance of these figures cannot as yet be fully appreciated in terms of dependence and addiction. However, surveys to date of the distribution of barbiturates as reported by the Division of Narcotic Control, Department of National Health and Welfare, which began to take these preparations under scrutiny in September, 1961, would seem to indicate that there is quite a sizeable drug problem in our population relative to this chemical.

However, the actual incidence of chronic barbiturate addiction is as yet difficult to estimate since it is not a reportable condition. Also, it is so often associated with alcohol or with other drug addiction that it is not recognized as such by physicians, or it is misdiagnosed for an organic nervous system disease. Possibly one of the reasons for the emphasis being placed on other conditions than barbiturates is the fact that until recently it was commonly held that these drugs did not produce dependence and so could be used safely to palliate the symptoms of various other types of illness. This was partially produced by the advertising pressure of the drug houses who have finally, since 1946, put "May Be Habit Forming" on their labels. Inadequate control of distribution was remedied in 1953 by more stringent legislation aimed at the loose handling of the drug by physicians and druggists and its availability to pedlars. Now, barbiturates alone, or in combination to a dose of 1/32 grains, require prescription. Further to this, in September 1961, barbi-

turates along with amphetamines came under control as outlined in the Food and Drug Act, Part III.

There is evidence, however, from the German literature that barbiturate addiction was recognized prior to 1939, as there are articles describing convulsions and/or a psychosis resembling the delirium tremens of alcohol following withdrawal of barbiturates from addicted persons. During this period, much attention was paid in the American and English literature to the effects of barbiturate intoxication to the exclusion of recognizing chronic addiction problems.

Suicides or Accidents?

Between 1922 and 1945, the increase in fatalities in the United States with barbiturates was 300 per cent and was exceeded only by carbon monoxide poisoning. Barbiturates are also the most common agents used in suicidal attempts and, as many people have pointed out, many of the suicides are not intentional but are the result of impaired judgment and memory.

Thus, individuals who are acutely or chronically intoxicated with the drug take more and more and finally kill themselves. In this way also the alcoholic, who after a night of drinking and having attained a high blood alcohol level, may take or be given by a physician or friend, some barbiturates which could potentially be fatal, since these two chemicals seem to have a synergistic action.

Such cases of barbiturate coma are medical emergencies and should be rushed to the nearest general hospital. Here a poison control centre, if available, will take the necessary steps to counteract the severe respiratory and circulatory depression. In general, the approach consists of lavage with magnesium sulphate, endotracheal intubation with oxygen therapy by pressure in the bag or continuous flow, intravenous fluids, non-convulsive electrical stimulation, and chemical stimulation with such chemicals as megimide, picrotoxin and other pressor drugs.

Statistics released by the Dominion Bureau of Statistics for Canada show that in 1960, barbiturates caused 56 of 212 accidental deaths while in 1961, the rate was 64 of 236 accidental deaths. In the suicide group, although the exact figure relative to barbiturates is not known, it is reported that in 1960, poisoning by analgesic and soporific substances caused 118 out of 1,350 suicides, and in 1961, the figure was 140 out of 1,366 suicides. A report from the coroner's office in Vancouver revealed that there were 22 deaths attributable to barbiturates in 1960, 33 in 1961, and 31 during the first six months of 1962. In Toronto, the coroner's office does not differentiate the cause of death other than "Poisoning by analgesics and sporofics" and the incidence of barbiturates is implied as high. In Toronto there were in 1959 — 42 deaths from analgesics or soporifics, of which 13 were male and 29 were female; in 1960 — 39 deaths, of which 16 were male and 23 were female; and 1961 — 55 deaths, of which 22 were male and 33 were female.

There is a need for some control in the amounts of barbiturates that are prescribed to a new patient to reduce the possibility of the initial prescription being a lethal dose, until both the patient and the condition are better known to the doctor. This should be done, in my opinion, even at the risk of complaint by the patient of increased cost or frequency of need for refill of the prescription as being in the long run in the best interests of the safety and welfare of the patient.

Barbiturates and Alcohol — A Parallel

Most of those who use the drug for the purpose of chronic intoxication prefer the short-acting potent types, such as Seconal, tuinal, Amytal and Nembutal, rather than the longer-acting drugs, such as phenobarbital and barbitol. The drugs are usually taken orally, although it is reported that some of the narcotic addicts will inject them intravenously. The use of barbiturates parallels the pattern of the use of alcohol. They may be taken for a one night stand, or for short bouts, or over long periods of time, for months and years. Until recently, they could be obtained without a prescrip-

tion, or on the strength of an old prescription, without the doctor ever being informed. This occured early in my experience when an original prescription for a woman suffering from symptoms related to anxiety state — for 24 capsules — was prolonged for approximately two years without my knowledge, and during this period she went through a normal gestation being delivered of a normal child before I saw her again suffering from chronic intoxication, at which time she was on a dose of 18 to 20 grains of tuinal per day.

Here again, the need for a written prescription each time, rather than a verbal order might be better preventive medicine. Also, the Narcotic Control Division may be able to report the type of patient who shops from one doctor to another to the doctors concerned for their information and action.

Tolerance Varies

The amount of daily intake, as with alcohol, to maintain a state of chronic intoxication varies from patient to patient once the upper limits of tolerance have been reached. The effects of the same dose vary markedly in the same person from day to day. Doses which one day will produce marked intoxication and even coma will another day produce only mild signs of intoxication. This variation in effect, as with alcohol, may be produced by as little as one and a half grains and is partially related to the food intake. The effects of the drug on the mood of the addict are also variable and appear to be related to the prevailing mood of the individual. One day he may be garrulous and happy, on another downcast and weeping. As with alcohol, barbiturates seem to accentuate the basic personality pattern in the individual. Extraverted individuals are usually euphoric, talkative and humorous; shy persons more withdrawn; schizoid and cyclothymic personalities show greater mood swings.

Persons addicted to barbiturates develop a partial tolerance to the sedative and hypnotic effects of the drug. In fact, those who

use these drugs sleep only an hour or two more per day than they do normally. It is probable that no tolerance can be developed to the lethal effect of these drugs, so that taking a large dose by the disturbed addict may be just as likely to cause death as is ingestion of the same dose by a person who is not addicted to these drugs. Tolerance to one type of barbiturate in animal experiments conferred partial cross tolerance to others.

There would appear to be, as reported by Jacobsen, a cross-tolerance phenomenon in people with regard to alcohol, barbiturates, meprobamate (Equanil and Miltown), and chlordiazepoxide (Librium). Another factor which influenced the control of both barbiturates and amphetamines is the use of these drugs by the same person so that one will counteract the effect of the other. In other words, a person who was pepped up or high on amphetamine would use barbiturates to sleep and the person who was drowsy or hung-over with barbiturates would use amphetamine to liven up. In this way, tolerance to very large doses of each could develop.

Predisposing Factors in Addiction

From the point of view of etiology, as with narcotics and alcohol addiction, personality disorders appear to be the most important predisposing cause of addiction to barbiturates. The psycho-neurotic group, most commonly obsessive compulsives with a high degree of anxiety, are often introduced to the drug by physicians in order to induce sleep. The need for this drug may become more prolonged in many of these people who then develop a psychological dependence with a gradual increase in dosage until intoxication may be reached. One of the procedures in hospital practice — which has been common to my experience as well as the experience of others with whom I have discussed it — is the problem of the nightly requests of the nurses on the ward for a nightly order of laxative and sedative. This is a ritual that in his ignorance, and with a desire

to please, the intern signs his name to and which results in potentially an indifferent attitude toward the use of barbiturates as well as forming an unnecessary association in the patient's mind relating these drugs to sleep ability.

The psychopathic personality uses the drug to obtain intoxication rather than sleep, and such a person tends to elevate the dose rapidly from the onset. In both these groups, we have those who use the drug either along with alcohol or narcotics when these may not be available, or to reinforce the effects of these other drugs. Addictive use of barbiturates by opiate addicts has become quite common; about 20 per cent of white opiate addicts are also barbiturate users. Another source of introduction that I have encountered has been in the alcoholic who has been given the drug during the withdrawal phase from alcohol and who has found he experienced a similar effect but now with a substance that did not smell, that he could hide better and which did not interfere with his appetite, and so he could take the drug for a longer period of time. A similar relationship appears to be growing in this way relative to the use of certain tranquilizers.

The Clinical Picture

The clinical picture of chronic barbiturate intoxication is identical with that of moderately acute intoxication. The phenomena observed are predominantly due to the effect of the drug on the central nervous system and may be divided into mental and neurological signs. The mental signs of barbiturate intoxication include impairment of intellectual functioning, confusion, poor judgment, depression, melancholia and psychic regression.

Individuals addicted to this drug neglect their appearance, become unkempt and dirty, unshaven and wear soiled clothes. They have difficulty in performing simple tasks and in performing simple psychological tests. They are irritable, morose and quarrelsome and very unreasonable to any approach on the part of the

physician. Their judgment is so impaired that even when they are so intoxicated that they can't walk, they will continue to take the drug. This condition has been labelled automatism and may lead to death. They are careless with cigarettes and constitute a very real fire hazard. They become so depressed that suicide may be a real possibility. They regress to an infantile level — have to be waited on, fed, nursed and will soil the bed and lie in the filth. Emotional control is impaired and they are likely to fight over minor incidents or fancied insults. Some addicts become hostile and develop mild paranoid ideas. While taking the drug, the addict is usually correctly orientated in time, place, and person, and seldom has hallucinations or delirium. True toxic psychoses are rare while on the drug, unless superimposed on some other form of chronic mental illness.

The neurological symptoms may be quite marked and may be suggestive of organic disease such as Parkinsonism, multiple sclerosis, cerebellar tumor, and general paresis. The signs observed include ataxia in gait and station, dysarthria, nystagmus, adiadokokinesis, hypotonia, tremor, decrease in abdominal reflexes, occasional ankle clonus and Babinski sign. There are no sensory changes or deep reflex changes unless there are superimposed nutritional changes which are rare since barbiturate addicts, who take no other drug, usually maintain a good state of nutrition as compared with the alcoholic.

Effects of Withdrawal

Prior to 1949, the majority of the papers that occurred in the American and English literature stated that no abstinence symptoms occurred in withdrawal of these drugs The German investigations have been more astute and have recognized since 1912 that convulsions and delirium may follow abrupt withdrawal of barbiturates from the chronic intoxicated patient and have recognized the similarity between the abstinence syndrome and the delirium tremens of alcohol. After 1940, there appeared some articles in

the American literature reporting abstinence symptoms produced experimentally in animals and clinically in man.

In 1950, Isbell and his group conducted an experiment in which a group of five morphine addicts were withdrawn from the narcotic for a period of time and then exposed to barbiturates for periods ranging from 92 to 144 days. Following withdrawal, some of these patients developed convulsions, some presented a picture of delirium, and some exhibited both. These symptoms did not occur while they were taking the drug and complete recovery occurred without evidence of damage that could be deduced by clinical or psychometric evaluation.

The Physician's Role

In the withdrawal phase, the physician should orient his activities toward the primary object at hand, namely withdrawal of drugs. His role should be sympathetic and understanding but firm, and discussion of problems likely to arouse intense emotional reactions should be avoided. On the other hand, he should be alert to the development of severe depressive reactions because of the danger of suicide, especially immediately after all drugs have been withdrawn. Fortunately, such disasters have occurred very infrequently, but milder depressions of temporary duration are not uncommon. Physicians who are confident of their own skill in the management of drug withdrawal generally have much less difficulty with patients who are quick to size up the therapist and to seize control of the situation if indecision, anxiety or hostility are deployed toward them.

When the drug is immediately withdrawn, the patients appear to improve for the first 12 to 16 hours. Their thinking and mental status become clearer and their neurological signs disappear. As the signs of intoxication clear, the patients become apprehensive and so weak they can hardly stand. Fasciculation of various muscle groups, and coarse tremor of hands and face, may be seen. The

deep reflexes are hyperactive and slight stimuli may produce excessive muscular responses. The patients cannot sleep, are nauseated, have abdominal cramps, may have diarrhoea and may vomit frequently. A weight loss may occur up to 12 pounds during the first 36 hours due to loss of body fluids and decreased fluid intake.

Concomitantly, there is an elevation of non-protein nitrogen, hypoglycaemia and hemoconcentration due possibly to dehydration. Changes occur in pulse and blood pressure and are marked when the patient stands. There are no clinical electrocardiograph evidences of myocardial damage. Weakness, tremor and anxiety continue. About 10 per cent of the patients will have one or more grand mal convulsions between the 16th hour and the third day but usually about the 30th hour. These may occur several times. The EEG will show paroxysmal bursts of high voltage slow waves before the convulsions occur, and may be present after the convulsion is past; after the abstinence syndrome, the EEG will return to normal.

Some patients show psychotic disturbances often heralded by 24 to 48 hours of insomnia. These patients will experience both visual and auditory hallucinations with the former predominating. The hallucinations resemble those seen in patients with delirium tremens. The emotional reaction will be governed by the basic personality of the patient. Some patients recover within three or four days while others may require two to three months. Improvement usually begins with the return of the ability to sleep.

Mechanisms in the Abstinence Syndrome

At the present time, little is known concerning the mechanisms that are involved in the genesis of the barbiturate abstinence symptoms. The fact that convulsions occur, after the withdrawal of drugs with anti-convulsant properties, suggests again that counter-adaptions may develop at cortical or sub-cortical cellular levels during chronic barbiturate intoxication. On the other hand, alternative hypotheses can be advanced, based upon recent evidence, that barbiturates exert selective depressant actions on the brainstem

reticular activating system, and the role of this on the diffuse thalamic projection system in the genesis of seizures is an interesting speculation. Unfortunately, practically no studies have been made in the neurophysiological changes that occur during recovery from the initial depressant effects of barbiturates. Carrying out of such investigations would entail technical difficulties of formidable proportions, but they appear to be necessary for the ultimate resolution of the problem.

The symptoms of the abstinence syndrome vary considerably from patient to patient. Some individuals escape without experiencing more than weakness and anxiety. Others have convulsions but not a psychosis and others have both.

Two Phases of Treatment

The treatment of barbiturate addiction, like that of alcohol or narcotic addiction, can be divided into two phases — withdrawal of the drug and subsequent rehabilitation and psychotherapeutic treatment. Abrupt withdrawal has been considered by Isbell to be absolutely contra-indicated. However, in my experience, a decision in several cases to carry out abrupt withdrawal has been based on the daily intake when the patient's history is reliable. With cooperative patients, I have had success in withdrawing the drug on an outpatient basis by a program of gradual reduction of dosage by one and a half grains per day. In those cases where the patient is withdrawn in the hospital setting, they are first stabilized on a dosage of their own drug or pentobarbital given every four hours to maintain them comfortably, and then their daily intake is reduced by approximately one and a half grains.

Sometimes it is necessary if the patient becomes apprehensive, nervous and weak, to elevate the dose and maintain him at that level for a day or two before carrying on with the withdrawal. Because of the danger of psychiatric disturbances, the patient should be observed at all times by nurses or attendants and physicians trained to recognize early manifestations. Since fully developed

barbiturate withdrawal psychoses are not readily reversed, it is better to err on the side of excessively slow reduction than the opposite. In severely addicted individuals, a month or more may be required for complete withdrawal of barbiturates.

Co-Existing Addictions

If barbiturate and opiate addiction co-exist, as is not infrequently the case, then withdrawal of the opiates should be accomplished first, while the patient is stabilized on barbiturates. Curiously, many patients who tolerated a given daily stabilization dose of barbiturates well previously, will exhibit more evidence of barbiturate intoxication after opiates have been withdrawn. In such cases, the stabilization dose may be reduced somewhat before systematic withdrawal is initiated. The use of anti-convulsant medication such as Dilantin and Mysoline has been tried, but their effectiveness is hard to evaluate due to the lack of controls. Isbell has been of the opinion that their effectiveness is very controversial and feels rather that the important thing to remember is a slow and prolonged withdrawal phase lasting up to 21 days if necessary.

General rehabilitation measures consist of dietary, social, vocational, and recreational procedures. Small doses of insulin before meals often aid the dietary problem although appetite usually returns to normal after the withdrawal period. The general rehabilitation measures are only supportive. Psychological treatment directed toward the patient's personality needs is necessary if any constructive result is to be expected. Group therapy and other specific therapy such as ECT may be necessary when indicated.

After the withdrawal period has been successfully accomplished, a more detailed psychological study of the patient may be made in order to start a psychotherapeutic program aimed at reducing the underlying factors in the addiction and so prevent relapse or at least to reduce its incidence.

When individual therapy is found to be suitable it must usually be planned over a long period of time. Many of the older addicts

with fixed patterns will not be as suitable for such therapy as the younger addict in whom the ego strength is relatively well developed and who expresses, or is capable of expressing, overt anxiety and whose goals and strivings show a good contact with reality and an awareness of social and cultural demands.

Complications of Psychotherapy

The problem of psychotherapy is complicated. What the psychotherapist does, says, looks for, finds, misses, emphasizes or ignores, depends to a great extent on the body of concepts concerning behavior which he accepts as valid and relevant to the problem at hand, and these, in turn, determine to a considerable degree the response elicited from the patient. Yet, validation of such concepts by the scientific test of predictive utility, has proved to be a difficult task in all areas of interest to psychiatrists, including that of drug addiction. Thus, it is not surprising that psychiatrists differ widely in their views concerning the psychodynamics of drug addiction and the particular problems which should be explored in formal psychotherapy. Hence man must be seen in his addiction as a whole, and treated as such.

The prognosis in chronic barbiturate addiction must always be guarded. In my experience, those patients with character disorders showed evidence of multiple addiction and did very poorly. In the psychoneurotic group, many had been started on drugs by a physician to relieve their insomnia, and these people showed good motivation with a higher recovery rate with psychotherapeutic help after withdrawal.

Education and Control Are Required

There is no doubt about the need for education and research in this field. Education of doctors and the public towards using fewer hypnotics, as well as research to produce effective but less toxic ones, is indicated so that in the future men plagued with insomnia and anxiety may require fewer pills or chemical comfort

but may have at their disposal safer drugs when needed. In education, a philosophy is required which stresses the need to face and understand problems as being better than our present slogans of finding "fast, fast relief" in chemicals.

While there is no doubt that barbiturates are effective and valuable drugs, we must be cognizant of their ever increasing consumption. Many cases (the true numbers as yet unknown) of habituation and addiction, as well as an increasing incidence of accidental over-dosage and suicide should cause us to look at the problem seriously, and we must not fail to consider the needs of the total person who is being prescribed one of these drugs.

To achieve the end of more effective knowledge about control of barbiturates, information currently being gathered by the Narcotic Control Division of the Department of National Health and Welfare, may lead to the conclusion that a more rigid prescription control, as with narcotics, would be to the ultimate advantage of both the patient and the medical profession, even though at first it would be considered a nuisance by both. ■

Treatment of Narcotic Addicts With Drugs A Medical Matter

The Narcotic Addiction Conference held at Niagara Falls, Ontario, February 22 - 24, 1963, under sponsorship of the Alcoholism and Drug Addiction Research Foundation of Ontario, brought together professional men and women with relevant experience. They represented a variety of approaches to narcotic addiction — those of psychiatrists, pharmacologists, psychologists, sociologists, lawyers, police officials, prison rehabilitation personnel, and some community organizations concerned with the recovery of addicted persons.

It became apparent as the meeting progressed that there are many approaches to the treatment of narcotic addiction and to the larger social problem of its prevention. Clearly no single view or

practice could be expected to meet all aspects of the factors involved.

The conference was greatly interested in the approach to one group of Canadian addicts in England. These had come under the care of Lady Isabella Frankau, M.D., a British psychiatrist — and a special guest of the Foundation sponsoring the Niagara Falls meeting. Lady Frankau made it clear that she would undertake the treatment of such patients only on condition that they fully understood that their goal would be ultimate withdrawal from drugs. This might take a number of months, but as their psychotherapy and re-establishment progressed they would be learning to live comfortably on ever smaller doses. Finally, they would be hospitalized for a short time and the drug would be completely removed. Lady Frankau's degree of success with this group of Canadian patients has been such as to commend her method to the Ontario Addiction Research Foundation for investigation in the Canadian setting.

It emerged from a discussion of the Narcotic Control Act of 1961 and its Regulations that there is nothing in Canadian law to prevent the use of Lady Frankau's approach to treatment being tried in Canada as the law now stands.

There Is No "British System"

The conference also learned that there is no such thing as "a British system" for the treatment of narcotic addiction. And most certainly there is in fact nothing approaching the popular myth that "all an addict in Britain has to do is register as an addict and collect free drugs for the rest of his life".

On this point of "a free dispensary for registered drug addicts" the meeting was explicit and unanimous. They agreed that the notion of such a thing as a free narcotic drug dispensary is contrary to the aim of good medical practice and should not be encouraged or permitted. ■

Culture, Law and Religion to Highlight A.R.F. Residential Summer Course

The cultural, legal and religious aspects of alcohol and alcoholism will highlight the Foundation's second Residential Summer Course on Alcohol and Problems of Addiction, co-sponsored by the Faculty of Medicine, Queen's University, to be held June 9th to 21st at Kingston.

Dr. E. M. Jellinek, world authority on problems of alcohol, has accepted an invitation to present lectures on the symbolism of drinking, drinking patterns in different cultures, and the various kinds of alcoholism.

The **Faculty of Law** at Queen's is cooperating with the Foundation in planning presentations of mutual interest to be held during the second week of the course, when the law faculties of both **Queen's** and **Dalhousie Universities** will co-sponsor a second seminar session devoted to problems of sentencing, with emphasis on the persistent offender.

Royal Military College will be the setting on Sunday afternoon, June 15th for **"A Religious Perspective"** on alcohol and alcoholism. This program will take the form of a symposium, with religious points of view given in brief papers presented by representatives of the United Church, the Roman Catholic Church, The Salvation Army, and the Jewish faith. **Dr. W. E. Boothroyd,** a psychiatrist trained in theology, will chair the symposium which will examine questions of moral theology related to the use of alcoholic beverages and the disease alcoholism. Sunday evening, an informal discussion will be led by **Dr. G. H. Ettinger,** the Foundation's Director of Medical Planning.

Inquiries should be addressed to the course director, Gordon M. Patrick, Alcoholism and Drug Addiction Research Foundation, 24 Harbord Street, Toronto 5. ■

The Alcoholism and Drug Addiction Research Foundation was established in 1949 by an act of the Ontario Legislature. It is financed largely by an annual government grant. The Foundation is empowered to (a) conduct and promote research in alcoholism and addiction to substances other than alcohol; and (b) conduct, direct and promote programs for (i) the treatment of, (ii) the rehabilitation of, (iii) experimentation in methods of treating and rehabilitating, and (iv) dissemination of information respecting the recognition, prevention, and treatment of alcoholism and addiction to substances other than alcohol.

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